Towards a Theory of Geographically Uneven Privatisation: The Case of New Zealand Public Hospital Ancillary Services

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A thesis

submitted in fulfilment

of the requirement for the Degree

of

Doctor of Philosophy

in the

University of Canterbury

by

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May 1990

In memory of

William Bowers Stubbs

1920 – 1990

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ACKNOWLEDGEMENTS

The opportunity for undertaking this thesis was made possible by the financial assistance received from the University Grants Committee which is gratefully acknowledged. Throughout the entire project an incalculable amount of encouragement and critical comment was given by my supervisor Dr Ross Barnett, Department of Geography, University of Canterbury. The formative stages of the thesis also benefitted from discussions with Dr Chris Connelly, Department of History, University of Canterbury and Professor Richard Bedford, Department of Geography, University of Waikato. Indebtedness is also expressed to Dr Pip Forer, Department of Geography, University of Canterbury, for reading and commenting on the final draft and to Mr Alastair Dyer for drawing the diagrams and doing the cartography.

During the research for this thesis much help was given by Area Health Board personnel, members and officials of the Hotel and Hospital Workers Union, and managers and employees of private contracting firms. Particular thanks is extended to:

Ms Yvonne Claperton, Secretary Whangarei Branch, Northern Hotel and Hospital Workers Union,
Mr David Dawe, Executive Manager Support Services, Canterbury Area Health Board,
Mr Paul Harris, Reserch Officer, Service Workers Federation of Aoteoroa (New Zealand),
Mr Chris Higgins, Director Information and Services Unit, Northland Area Health Board.
Mr Robert Hutcheon, Union Organiser, Canterbury Hotel and Hospital Workers Union,
Mr John Ryall, Union Organiser, Wellington Hotel and Hospital Workers Union,
Mr Peter Schultz, Executive Officer, Provisions and Services, Auckland Area Health Board,
Mr Robin Startup, Manager Planning and Administration, Wairarapa District, Wellington Area Health Board,
Ms Susan Stewart, Union Organiser, Canterbury Hotel and Hospital Workers Union.

A special word of thanks is due to all those area health boards and Hotel and Hospital Workers' Union branches who gave me access to their records and written documentation pertaining to private contracting. Much assistance was also given by various hospital ancillary workers who, still being employed by either area health boards or private contractors, should remain anonymous.

Finally, but by no means least, much appreciation is extended to Mary Anne Ryan without whose unceasing support and forbearance this thesis could not have been written.

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ABSTRACT

This thesis seeks to formulate a theory that explains the geographically uneven development of privatisation. The New Zealand public hospital ancillary services are taken as a case study of uneven privatisation, and the process of privatisation is analysed within terms of the three major theoretical frameworks used in social geography; public choice theory, Weberian managerialism and Marxian class conflict. Empirically it is found that geographically uneven privatisation occurs within three dimensions; the spatial, the temporal and the sectoral. This raises the questions, why privatisation in region A but not B, why at certain times and why in certain industries or sectors of industry but not in others? The answers to these questions are sought in the context of the three theoretical frameworks used in the thesis, as applied to hospital ancillary services.

The empirical research reveals that the implementation of privatisation policies is mediated by several regionally variable factors, such as the size of institutions, hospital authority management structures, location to major urban settlements, levels of financial restraint on hospitals, and the labour militancy of the work force. The explanatory significance of these factors varies substantially according to the time and place at which privatisation occurs and the particular sector of the public hospital system being considered. Many of the explanatory factors contradict each other, insofar as some may predispose public authorities to privatise whereas others may inhibit the process. The complexity of the uneven development of privatisation renders inadequate any single theoretical explanation of the process. Nevertheless the research presents an understanding of how privatisation develops across space and time and an insight is also gained into the likely future uneven development of public service provision.

INTRODUCTION

The Social, Spatial and Political Extent of Privatisation:

Few issues during the 1980s have aroused more controversy than privatisation, and debates on the subject have extended far across both the political spectrum and national boundaries. While the privatisation policies introduced in Britain during the 1980s have received most publicity they have spread much further afield, as many governments across the world appear to have embraced the idea with considerable enthusiasm. One ardent advocate of privatisation has remarked that Britain has been very much "*the trail blazer*" and that, "*despite its novelty* [privatisation] *rapidly became one of the most important factors of the 1980s spreading outward from Britain to affect more than 100 countries throughout the world*" (Pirie 1985, 3).

Privatisation has come to be seen as almost any process involving the transference of goods and service provision from the state to the private sector. One aspect of this process that has received much publicity is the selling of state assets. For example, a headline in the *The Observer* (1987) newspaper of London pronounced that, "*All the World's a Stage for Sell Offs*" while only two years earlier an article in *The Economist* (1985, 71) of London entitled, *Privatisation; Everybody's Doing it Differently*, illustrated the geographical ubiquity of privatisation. The claim was made that, "*The selling of state assets from airlines to jute mills is captivating politicians everywhere even in socialist Spain and communist China*" (*The Economist* 1985, 72).

If the current impetus for privatisation has emanated from Britain it is perhaps not surprising that much of the literature on the subject has focused on the UK experience. Particularly detailed accounts have been provided by Kay *et al* (1986), Veljanovski (1987) and Vickers and Yarrow (1988). Other works have sought to include a broader geographical scope in their discussion. The contributions to MacAvoy *et al* (1988) cover the development of privatisation in the USA and Canada as well as the UK, while Fraser and Wilson (1988), although still focusing largely on the UK, also examine the international extent of the process by considering, Western Europe, Japan, Australasia, North America and the Third World. Some works on privatisation have been devoted specifically to regions outside the UK. Vickers and Wright (1988) focus on Western Europe while the contributions to Hanke (1987) centre predominantly on the USA. Roth (1988) devotes his entire work to the private provision of public services in developing countries and, specifically within the New Zealand context, McKinlay (1987) has examined privatisation and the closely associated process of

corporatisation.

Not only has privatisation been implemented on a very wide geographical basis but the range of industries involved has been equally extensive. Virtually no sector of the economy seems to have been exempt from some attempt to privatise it although much variation remains between sectors in the extent to which the policy has been pursued. In broad terms, accounts of privatisation have tended to concentrate their attention on one of the two major areas of the economy; the industrial (productive) sector or the welfare (consumptive) sector. The reasons for this divided attention may possibly be attributed to the different forms of privatisation that have been adopted in each one.

The focus for writers examining industrial privatisation has primarily been the selling of state assets and enterprises to the private sector (eg Veljanovski 1987, Vickers and Yarrow 1988). Some writers, such as McKinlay (1987), have written on 'corporatisation, whereby state owned industries are restructured in order to operate in accordance with private sector principles while still being state owned. In respect of the welfare sector, studies of privatisation, such as Ascher (1987) and RIPA (1984), have analysed the contracting out of public service provision to the private sector. The essays in LeGrand and Robinson (1984) and Papadakis and Taylor Gooby (1987) have looked at the imposing of service user charges, the complete closure of public institutions, the withdrawl of public services or of government grants and subsidies, and the growth of private and voluntary welfare agencies to replace former public ones. The contributions examine both the potentialities and the realities for implementing these privatisation processes in the field of housing, health, education and public transport.

Another process closely associated with privatisation, and indeed sometimes regarded as a distinct form of privatisation itself, is that of market deregulation. The existence of a deregulated market in which the state does not restrict the number of private sector operators is seen by most advocates of privatisation to be crucial for the efficient working of the economy in both the industrial and welfare sectors whether publicly or privately owned. Many accounts of privatisation have therefore given much attention to the attendent process of deregulation (eg Kay *et al* 1986).

The most cursory examination of the literature on privatisation reveals that the process has taken place in different geographical regions and amongst different industries and services. Another clearly defined feature in this literature is the different political perspectives upon which much of it is based. Drawing theoretical inspiration from public

choice theory, with its basis in neo-classical economics, a great deal of the literature produced has been unambiguously in favour of privatisation. Most of the contributions to Hanke (1987) are decidedly within this category. By far the most vociferous proponents have been writers such as Pirie (1985) and Savas (1987) who belong to right wing research organisations, commonly called 'think tanks'. The UK based Adam Smith Institute and The Heritage Foundation in the USA are two notable examples.

Taking an opposing view to privatisation, and coming from a generally left wing political persuasion have been the publications produced by trade unions whose members have been adversely affected by the process. *Public Service Action* which carries the subtitle *The Anti-Privatisation Magazine of the Labour Movement* is widely distributed in the UK, in trade union circles at least, and published monthly. In New Zealand the Public Service Association has produced publications expressing a similar point of view (eg NZPSA 1989).

More on the consumer (rather than producer) side, service user groups like London Health Emergency and Transport 2000 have produced, respectively, material such as *Privatising Health Care* (Newbigging and Lister 1988) and *Rails for Sale?* (Transport 2000 1989) both of which take a distinctive anti-privatisation stance. Hastings and Levie (1983) provide one of the few book-length works that is openly opposed to privatisation. Other predominantly anti-privatisation works have appeared as contributions to book-length publications, most of which contain accounts written from more conservative perspectives (see Thomas in Steel and Heald (1984) and Starr in Hanke (1987).

In spite of, or may be because of, the distinct polarisation in political stances on privatisation, some writers like Ascher (1987) and RIPA (1984) have claimed to take a non-partisan or 'dispassionate' view of the subject with 'objectivity' being the goal rather than the advocation of ideologically biased policy prescriptions. To take just one example, Bailey (1987, 151) writes that:

> For the public manager [privatisation] should not be a matter of ideology, however, but of informed judgement based on experience in public management and on policy analysis more exacting than is currently presented by advocates of privatisation.

Missing however from these supposedly non-partisan accounts, and not surprisingly in view of their claimed objectivity, is any discussion of the political underpinnings of their own analysis. Implicit within such works, although seldom made explicit, is the contention that only where privatisation can be shown to exhibit a definite public benefit can it be

justified. Questions concerning which individuals, groups or social classes may have access to such public benefits are seldom addressed less still answered. The implication is that there is, or at least can be, some common universal consensus regarding the public interest and privatisation. Almost a quarter of a century ago, Pahl (1967, 219) wrote of, and demonstrated, 'the myth of a value free geography'. Arguably then, a 'value free privatisation' is equally mythical. It appears that few, if any, of the works produced on privatisation are cognisant of this, although some are much more honest about their political biases than others.

This brief review of the privatisation literature has by no means been exhaustive and it has been confined mainly to book length publications and special issue editions of certain periodicals. The references cited illustrate the social, spatial and political dimensions that privatisation encompasses rather than covering the complete literature. One point however that should be clear from this review is that privatisation has not occurred in a spaceless environment but has instead had a distinct geographical basis. This raises the immediate question of the contribution of the geographical literature to the privatisation debate.

The Geography of Privatisation:

Many publications have titles or chapter headings that refer directly to either *The Economics of Privatisation* (Hanke 1987) or *The Politics of Privatisation* (Ascher 1987) or *The Political Economy of Privatisation* (Walker 1984) but works detailing *The Geography of Privatisation* are very thin on the ground, which is as surprising as it is disappointing. Although much of the literature reviewed above admits of a geographical dimension there has been little systematic analysis of this aspect of privatisation. Indeed, rather than analysing the geography of privatisation, geographers themselves appear to have been much more preoccupied with broader analyses of 'industrial restructuring' as evidenced by the work of Massey and Meagan (1982), Massey (1984), Peet (1987), Martin and Rowthorn (1986) and Hudson and Williams (1986). Except for the last publication listed, which contains various refences to privatisation, the process barely receives a mention in the others. Even with Hudson and Williams there is no detailed analysis of the process, which is no small deficiency in a work on the contemporary industrial and social geography of Britain.

The work geographers have produced on privatisation has been almost entirely devoted to the welfare sector of the state. The privatisation of housing in Britain, in the form of local authority (council) house sales,

has been described in detail in a series of four papers in *Environment and Planning* by Crook (1986). Tosics (1987) has examined the differences between western countries and Hungary in the privatisation of housing particularly as it affects inequalities in consumption between social groups. In the case of (surface) public transport provision, the possible social and economic consequences of its privatisation and deregulation upon service users in Britain has been studied by Farrington (1985) while Rimmer (1988) has examined the origins and uneven expansion of these processes in the South East Asian context.

Within the field of privatising health care there has recently appeared an edited collection of works by geographers (Scarpaci 1989a), and as far as is known this is the only book length work specifically by geographers on the subject of privatisation. The contributors base their studies on either a particular area of health care or on certain geographical regions or nation-states. From detailing the growth of private hospitals in New Zealand (Barnett and Barnett 1989) and the USA (Bohland and Knox 1989), the material extends to considering the role of multinational pharmaceutical firms in the Third World (Gesler 1989) and to the dismantling of public health services in Chile (Scarpaci 1989b). Some of these writers in Scarpaci (1989a) have also published separate material on health service privatisation. Mohan (1988) has written about moves to privatise and restructure the British NHS while Laws (1988) has looked at the privatisation of a variety of welfare services in one specific region - Ontario, Canada.

If the existence of a geographical basis to privatisation is overwhelmingly apparent from the literature, a feature that is almost equally clear is the manifestly uneven spatial development of the process. In both industrial and welfare sectors of the state, privatisation has occurred in different ways and to various extents. There remains however a distinct gap in the literature reviewed here. Little attempt seems to have been made to explain, within a theoretical framework, why privatisation should develop so unevenly across space. A possible exception is Eyles (1989) who examines the uneven development of welfare state privatisation between western European countries. Drawing on the work of Esping-Andersen (1985), countries are classified as belonging to three broad 'regimes of [welfare] distribution', and different levels of privatisation are identified for each one. Left unexplained by the account though is any variation of privatisation between the countries falling within these three 'regimes'. It is towards addressing this question of explaining theoretically the uneven development of privatisation that this

thesis is devoted.

The Inadequacies of the Privatisation Literature and the Contribution of the Thesis to Geographical Research:

One possible reason for the above mentioned gap in the literature, although by no means an excuse for it, is that so much of the work on privatisation has been produced in edited volumes containing contributions from different writers. Each contributor has focused on their own particular point of interest on privatisation, whether sectorally or regionally based, with little or no attempt being made to synthesise the contributions into a coherent analytical framework. In effect a series of rather disparate case studies has been presented reflecting writers' individual interests rather than the need to address unresolved theoretical issues.

With reference to Scarpaci (1989a) again, there is undoubtably a clear recogition of an uneven spatiality in the privatisation of health care but attempts to provide any coherence to the various empirical contributions are confined to the final three pages of the 274 page text. Even then the presentation is more of a general description of trends rather than a theoretically informed analysis. By way of illustration Scarpaci (1989a, 272) observes that:

> In national politics in New Zealand, for example, the rise in private hospital and geriatric care has evolved gradually since the Second World War, but community opposition to hospital closures in New York City has arisen over a shorter period of time and within a smaller geographic area. Within the United States, the growth of proprietary hospitals has depended on a particular type of investment capital and has needed particular locational criteria for hospital markets.

While certainly highlighting the geographical variations inherent in the development of privatisation it does little to advance any theoretical understanding of why the process develops unevenly across space. To what extent one may ask is community opposition to hospital closures a factor in determining the spatiality of hospital closures, not only in New York but across a much wider geographical region? Similarly to what extent has location to markets and sources of investment capital been a factor in the spatial growth of private hospitals when considered across a variety of regions or nation states? A critical question then is whether the empirically observed factors are merely idiosyncratic to the particular aspect or region of privatisation under consideration, or are they applicable to a general theory of spatially uneven privatisation? Questions such as these are left unanswered by the geographers contributing to Scarpaci (1989a). Neither for that matter have any other

writers, geographers or otherwise, sought to address this issue in any other area of industrial or welfare activity.

It is towards addressing this major theoretical gap in the literature that this thesis is devoted. The central question posed is simply why does privatisation develop unevenly across geographic space? Such a question is far from being of mere academic interest but is rather one of critical importance to communities, service user groups and workers having to confront the effects of spatially fragmented privatisation initiatives. The extent to which uneven development of privatisation can be explained marks the prime contribution of this thesis to geographical research. Indeed it may be added that after almost a decade of privatisation, geographers have been distinctly remiss in their failure to undertake such research.

As already indicated, privatisation has occurred on a very broad social and spatial dimension. In view of the limitations of time and resources, the research conducted here has had to confine itself to explaining spatial unevenness of the process in just one industry in one country. By examining, within a theoretical framework, the contracting out to the private sector of public hospital ancillary services in New Zealand it is intended in this study to be able to formulate some explanations for the uneven development of privatisation policies in general.

The Structure of the Thesis:

The thesis is presented in ten chapters, the first four of which are concerned with conceptual and theoretical issues. In the subsequent five chapters an empirical case study is presented which is followed by a concluding chapter where there is a return to theoretical considerations. The first chapter is mainly devoted to conceptual matters and primarily addresses itself to the question, what is privatisation? Concepts such as, private, public, market and state, all of which are fundamental to understanding the privatisation process, are analysed from three different political perspectives on political economy - classical, liberal and Marxian. These same three perspectives are used to analyse the ideological basis underlying the use of the term, 'the public interest' in relation to implementing privatisation policies.

Chapters two and three build on the conceptual foundation laid down in chapter one and detail the theoretical frameworks that purport to explain the implementation of privatisation policies. Here the basic question is, why privatisation? In chapter two attention centres both on public choice theories with their origins in classical political economy and on Weberian managerialism, founded more on the liberal social democratic

tradition. The intention is to assess their explanatory power in relation to the spatial unevenness of privatisation. A similar methodological approach is adopted in chapter three which discusses the application of Marxian political economy to privatisation. The theoretical shortcomings of all three frameworks is highlighted and the need established to conduct empirical research in order to acquire a more refined theory of uneven privatisation.

The fourth chapter returns to conceptual issues again and seeks to identify the qualitative differences between various forms of privatisation that may be resorted to. In this chapter the main question posed is simply, how privatisation? A detailed examination is undertaken of the different processes by which contracting out for goods and service provision may occur, and a critical review is made of one of the major contributions to this form of privatisation.

In the fifth chapter, which marks the start of the empirical section of the thesis, an overview is given of the privatisation of health services in general with particular reference to hospital care. This provides background material for discussing the changing structure of the New Zealand public hospital system in respect of the administration and provision of services. Attention is also given to the social, economic and political pressures that have led to major changes in the hospital system in the late 1980s. A largely contextual treatment is presented which gives a framework for the empirical analysis conducted in the subsequent chapters.

Chapter six commences with an account of the growth of contract service provision for public hospital ancillary services, and attempts to analyse the spatial patterns of privatisation that are observed. The discussion looks at the explanatory significance of variations in hospital board size, management structures and the geographical location of the boards in relation to the main urban settlements. The weakness of any statistical correlation between these variables and the occurance of privatisation leads to the conclusion that attention must be given to socio-economic and political factors within both the institutions concerned and society as a whole. These issues are taken up in chapter seven.

This chapter looks at the historical origins of contracting out hospital services from around the time of World War Two to the end of the sixties. The process of contracting out is analysed in relation to developments in the New Zealand economy as a whole. Regional variations in the conditions of the labour market during the 1950s are identified in order to determine to what extent they mediated the spatially uneven growth

of contracting out during earlier times.

Chapter eight discusses the developments in contracting out that have occurred from the early 1970s to the contemporary period. Attempts to explain the changing spatiality of the process focuses largely on the increasing, but regionally variable, financial constraints imposed on hospital boards in the 1980s. Also considered for their possible significance for uneven privatisation are changes in political climate, at both national and local level, and alterations to management prerogatives within the hospital boards.

In chapter nine the attention focuses exclusively on the issue of labour militancy in response to contracting out. Here the problem is to determine the extent to which variations in workforce opposition to contracting out, across both time and space, have mediated the uneven development of the process. In other words, what effect has the campaign of opposition had on the geography of privatisation? The final chapter of the thesis is largely devoted to summarising all the empirical factors identified as being relevant to the geography of privatisation. An attempt is made to relate them to the theoretical frameworks of the thesis. Both the contributions and limitations of the thesis are assessed on the basis of the empirical work in the preceeding chapters and some comments are made on future geographical research on spatially uneven privatisation.

CHAPTER 1

Privatisation and the Public Interest

Privatisation, like the more general term 'restructuring' has come to have, "*a high level of use and low level of meaning in recent years*" (Pinch 1989, 905) and there has therefore been a great deal of confusion and ambiguity surrounding the use of the term. This first chapter then addresses the question, what is privatisation? In order to detail the range of controversy that abounds over the issue, the meaning of the term privatisation is analysed from three different theoretical perspectives on political economy; classical, liberal and Marxian. Although the precise contents of the subject matter of political economy may also be open to debate it is understood in this work to refer to the study of the relationship between the exercising of political power and the production of economic (material) wealth.

Central to much of the debate over privatisation has been the concept of the 'public interest' since the implementation of the former has often been justified in terms of serving the latter. In contrast much of the opposition to privatisation has been presented in terms of it being contrary to the public interest. Unless there is some understanding of what constitutes the public interest, and how the privatisation process relates to it, there is bound to remain a great deal of conceptual confusion in the debate.

This chapter seeks to clarify these issues and is presented in four parts. In the first part the theoretical inadequacy of commonly used definitions of privatisation is pointed out and a discussion is presented on the qualitative differences between concepts frequently referred to in these definitions. Principally this requires distinguishing market provision and private ownership from state provision and public ownership. Recognition of the oversimplification of a two sector model of the economy as a representation of reality leads to a discussion of the structure of the voluntary sector in relation to the state and the market.

In the subsequent three sections of the chapter, transfers of property ownership and service provision between the state and the market, or the public and the private, are discussed in terms of classical, liberal and Marxian political economy. The intention is to show how any understanding of privatisation and the public interest will vary significantly according to which form of political economy is applied to the debate. While the association with any overtly spatial issues may seem tenuous, the presentation of the discussion is justified in order to establish a firm conceptual foundation for developing theoretical

explanations of geographically uneven privatisation in subsequent chapters.

1.1 Privatisation: Towards a Conceptual Clarification:

> Privatisation is not an end in itself but it is a means to a better way of working and to higher standards of living. It is a means of reestablishing capitalism - people's capitalism (Lord King, chairperson of British Airways, quoted in *The Times* (of London), 19 June 1987, page 16, [emphasis in original] cited in Dear 1987, 363).

As a statement which clearly expresses the desirability of privatisation this passage would be difficult to surpass - 'better way of working' - 'higher standards of living' and, in emphasis, 'people's capitalism'! It is almost hard to see where the controversy lies. At least three important questions present themselves from the above statement. The first is whether privatisation does in fact achieve the ends claimed by Lord King. *Does Privatisation Work?* is the challenging title of a recent publication (Bishop and Kay 1988). The second question is what are the means "*to a better way of working...*" that Lord King refers to. Thirdly, the question still remains, what is privatisation?

Donnison (1984, 45) has pointed out that the term privatisation has been largely invented by politicians and widely used by political journalists. Perhaps not surprisingly therefore a multitude of definitions of the process exist, a selection of which is shown in figure 1.1. All primarily amount to saying, that privatisation represents simply a transference from state to market provision or public to private ownership. Such statements however merely beg the further question as to what is meant by the terms state, market, public and private as they affect the ownership of property and the provision of services. This issue is addressed in the following section.

1.1.1 Public and Private in Economic Activity:

Many commonly used definitions of public and private in economic life have tended to lack any firm conceptual basis. In the *Penguin Dictionary of Economics* (Bannock *et al* 1978, 358), for example, the private sector is defined as, "*that part of the economy not under government control*" (my emphasis). Likewise, Lane (1985, 7) argues that public ownership (of the means of production) is distinguished from private ownership simply on the basis of the former being government ownership from which one can reasonably, if not trivially, conclude that private ownership is non-government ownership. The geographical literature is by no means immune from this tendency to 'define by exclusion'. In a paper on the geographical basis of privatisation, Laws (1988, 434), refers to the

FIGURE 1.1 A Selection of Definitions of Privatisation

1 Ascher K. 1987, 7: *The Politics of Privatisation*:

An umbrella term that has come to describe a multitude of government initiatives designed to increase the role of the private sector. In its most literal sense, as it is used by the Thatcher Government, it refers to transfer of state ownership in nationalised industries to the private sector.

2 Beesley M. and Littlechild S. 1986, 35 in *Privatisation and Regulation: the UK Experience*:

The formation of a Companies Act company and the subsequent sale of at least 50 percent of the shares to private shareholders. However the underlying idea is to improve industry performance in increasing the role of market forces.

3 Blundell J. 1986, 5, 'Privatisation; by Political Process or Consumer Preference' in *Economic Affairs*, 7:

The process by which goods and services currently financed and provided by the state sector shift, either how they are paid for or how they are provided or both, to the private sector with or without concomitant changes in the regulatory climate.

4 Heald D. 1984, 21 in *Privatising Public Enterprises*:

An umbrella term for a diverse set of policies, albeit linked through an underlying judgement in favour of strengthening the 'market' at the expense of the 'state'.

5 McKinlay P. 1987, 3: *Corporatisation; The Solution for State Owned Enterprise?*:

In its narrow meaning [privatisation] describes the process whereby governments, such as that of Mrs Thatcher, have converted their trading enterprises into limited liability companies and then sold off the shares to the public.

6 *The Economist* 21st December 1985, 72: 'Privatisation; Everybody's Doing it Differently':

The best - and British - stab at a definition of privatisation is that it is a process which transfers ownership and control of a state asset to the private sector.

7 Walker 1984, 25 in *The Privatisation of the Welfare State* by Legrand J. and Robinson R. (eds):

[Privatisation is] when the responsibility for a service, or a particular aspect of service delivery, passes wholly or in part, to the private sector and when market criteria such as profit or ability to pay is used to ration or distribute benefits and services.

process as one which "*involves the transference of responsibility for service provision from the public sector to private (ie non-state) interests*" (emphasis mine). On these grounds the distinction between public and private can only be quantitive and therefore no conceptual distinction is possible.

A more analytically illuminating distinction between private and public sectors is made by Konukiewtz (1985, 181) who identifies:

> - a private sector in which goods and services are provided by private suppliers on the basis of value exchange in response to effective demand and,
> - a public sector in which goods and services are provided 'free' ie with a tax price on the basis of user fees or some other principle which is not related to the supply and demand mechanism of the market place.

Although there is still the element of 'definition by exclusion' in the latter part of the statement (ie .... some other principle which is not related....) this formulation does at least provide the basis for an analytical distinction between the public and private sector. The existence of value exchange, becomes the basic criteria for defining the private sector of the economy.

Value exchange occurs when products of production are exchanged at a rate that reflects either their embodied labour content, as in Marxian theory or their 'utility' as in neoclassical economic theory. Under the conditions of value exchange, the products of production are referred to as commodities and are distinguishable from goods and services consumed either by producers themselves (eg 'do-it-yourself' work) or by holders of political power (eg rent, tribute or tax). For exchange to take place at value there are two necessary conditions to be satisfied. The first is that there is competition between the owners of property or, more specifically, the means of production and second is that the production of commodities is profitable to the owners of property. In short no profit, no production. The delineating characteristics of the private sector can be characterised by the production of commodities for profit with market exchange taking place according to the value of the commodities.

By contrast, the public sector operates on the basis of production for a socially or collectively perceived need rather than for profit. The exchange of the products of production is rationalised according to a deliberately conceived plan by the holders of political power rather than by market mediated value. For example, prices (ie exchange relations) in the private sector are generally set by the conditions required for profitability in market exchange, whereas in the public sector prices

are more likely to reflect a plan by government to hold prices to a level consistent with some political or social objective such as with 'free at the point of use' hospital care and subsidised public transport. In the latter case, production for a social need defines the sphere of collective production. The private sector, however, is founded on production for profit rather than need and defines the sphere of commodity production. The latter is seen as the quintissential economic structure of capitalism and the former of socialism. The fundamental differences between the two sectors in terms of production and exchange are presented in figure 1.2.

FIGURE 1.2: Production and Exchange Characteristics of Private and Public Sector Economies

	PRIVATE	PUBLIC
PRODUCTION	PROFIT	NEED
EXCHANGE	VALUE	PLAN

Whatever the strength of these analytical distinctions, the empirical reality is that virtually all modern societies, whether claiming to be capitalist or socialist, contain arbitrary degrees of commodity and collective production. It should also be added that commodity production through value exchange is occurring to an increasing degree in (former?) socialist countries following the recognition of the seemingly insurmountable practical difficulties of economic organisation entirely by plan and according to need. The extent to which competition and market exchange is compatible with concepts of socialism has been the subject of much recent debate on the political Left, stimulated largely by Nove (1983, 1987) and the ensuing debate in *New Left Review* particularly Mandel (1988) and Elson (1988). As a detailed discussion of this issue is beyond the scope of this work, suffice to say that privatisation can most appropriately be seen as a means by which production, from being mediated by state plan, increasingly takes the commodity form mediated by competition and value (market) exchange.

Even if an empirically existing mix between public and private sectors is admitted, this two sector conception of economic organisation greatly oversimplifies social reality. There is a requirement to add a third one which is usually called the voluntary sector. This needs to be made conceptually distinct from the other two sectors. Even the most ardent advocates of privatisation and its associated free market economy, would

admit that 'market failure' can arise in which private production is not profitable through lack of effective demand (ie demand backed by ability to pay). Where social need for a commodity exists and the state does not undertake production itself, then the task falls to organisations outside of both the private (market) and public (state) sector.

1.1.2 Privatisation and Voluntarisation

In respect of the privatisation debate, the voluntary sector has often been taken as a part of the private sector, primarily on the grounds that it is organised outside of the state sector (Sugden 1984, 70). The theoretical shortcomings of defining by exclusion have already been made clear but the matter cannot rest here. In order to provide a distinction with (or rather within) the private sector and production for profit, the voluntary sector is usually identified (eg Weisbrod 1977) as being the 'not for profit' private sector. This however amounts to a virtual contradiction in terms where the private sector itself is defined upon the basis of commodity production for profit.

As the voluntary sector exists primarily to provide a social need rather than to make profit it cannot, on this basis, be distinguished from the state sector. The question to be addressed then is, what is the voluntary sector if it is constituted as being both non-state and non-profit? Citing Laws (1988, 435) again one is advised that, "*another call for 'privatisation' is the call for co-operative housing ventures. This form of housing offers an alternative to both commercial and public institutional forms of housing...*". Since she neglects to say how this alternative is structured in contrast to commercial and public institutions this statement is not very helpful for gaining conceptual clarifications.

Perhaps the first and most obvious point to note is that a whole multitude of institutions exist within the so-called voluntary sector ranging from churches and charities to trade unions and household domestic activities. Sugden (1984, 73) points out that many commonly termed 'non-profit' organisations, "*derive almost all their income from the sale of goods and services and compete on essentially equal terms with profit making firms*". They are virtually indistinguishable from private sector organisations with typical examples including 'voluntary', yet fee charging schools and hospitals. On the other hand there are institutions, "*that are so dependent on public money that their private status is purely formal*" (Sugden 1984, 72) with some universities being cited by him as a prime example of this. The important conceptual point, according to Sugden (1984, 72), is that in all such organisations there is a substantial, "*share of the cost of supplying services that is paid by voluntary*

contribution [donation] *whether of money or labour*".

It is the existence of voluntary contribution that provides the main conceptual distinction from the private and public sector. Each sector has its own specific form of funding. In the public sector the costs of supply are met by state levies and taxation from the public at large (collective production) while in the private sector they are met by private investment in the market place (commodity production). No voluntary donation is required in either of these two cases. Funding for the voluntary sector is, most fundamentally, reliant upon donations of either time or money from various sectors of the public or what is sometimes termed the community. By contrast with the respective commodity and collective production of the private and public sectors, the existence of the voluntary sector is based instead upon <u>community</u> production.

Viewed in an historical context much of the state sector has arisen out of 'voluntary inadequacy' as much as 'market failure'. The voluntary or charitable institutions were simply inadequate to ensure the requisite levels of health, housing and education for an industrial society. One of the intellectual founders of the welfare state, William Beveridge, is reported by Kramer (1985, 132) to have described the historical source of the welfare state as, "*voluntary action crystallised and made universal*". Another writer on the growth of the modern (capitalist) state de Jasay (1985) has commented that, "*the great practical utilitarian*" Edwin Chadwick clearly recognised that, "*if the state is effectively to promote a good cause it must not rely on the good will of independent intermediaries* [ie voluntary agencies] *whom it does not control*" (de Jasay 1985, 78).

Insofar as much contemporary state sector activity did at one time operate in either the private or voluntary sectors, privatisation can therefore be represented as part of a cyclical process over time. In the early days of industrial capitalism, the voluntary sector had to provide the consumption requirements for those sectors of society who could not obtain them through the market. There was in effect a process of 'voluntarisation' in operation even though it appears not to have been adopted as conscious policy decision by holders of political power.

In historical terms the growth of active state involvement in production and consumption has seen an extensive 'socialisation' or collectivisation of a least some of these two economic activities. The contemporary era of state activity may be characterised by a return to varying degrees to the greater private and voluntary provision of earlier times. The use of the term <u>re</u>privatisation might then be more historically sensitive to describe the contempory scene.

Even when some conceptual distinctions have been identified between public, private and voluntary sectors, the question remains as to why the transference in goods and service provision between the sectors is so controversial? Returning to Lord King's view of privatisation the 'reestablishment of capitalism' is presented as being decidedly in the public interest. The issue then becomes, what is the public interest, and how does it relate to the concepts just discussed? These issues are discussed in the next part of the chapter in which the classical, liberal and Marxian perspectives on political economy are applied to the conceptions of public or private ownership and state or market provision.

1.2 Public and Private Spheres of Human Activity in Classical Political Economy[1]

1.2.1 Self Interest and the Public Interest

The public/private distinction may be said to provide the bedrock of the work of the classical political economists[2]. The basic unit of analysis in their work is the individual upon whom the concept of private interests are built. These interests equate to the maximisation of satisfaction from goods and service consumption and it is claimed that, by pursuing private, or more specifically, individual interests, the public good (interest) may best be served. The public, in this view, is seen primarily as being an aggregate of private individuals and, according to Say (1964, 228) , "*a nation is but an aggregation of many individuals*" (cited in Gaus 1983, 184).

Within this perspective the public good, or the public interest, is held to lie in the maximization of total (public) wealth or income. The creation of this wealth should be the prime object of economic policy, hence the title of Adam Smith's major work *The Wealth of Nations* (1776). As O'Brien (1975, 30) states, for the classical political economists, "*the pursuit of* [private] *self interest (subject to an appropriate framework) ensures optimal resource allocation* [public good]". In simple terms, private interest equals public good with the former understood as individual self interest and the latter the good of everyone.

The mechanism through which private individuals achieve the public interest is through a system of competition with each other. This system is known generally as 'the market' in which voluntary exchange relations occur. Providing these exchange relations between individuals remain voluntary, in as much as there are no demands made by political authorities, the theory maintains that they are self regulating and can ensure, by means of Smith's 'invisible hand', that social harmony

prevails. The voluntary exchange of the market is seen as coinciding with a certain conception of human liberty and freedom and is contrasted with the coercive element involved in state directed production. While recognising that the market is a human, and not a natural, construction classical political economy maintains that it is particularly appropriate to human nature. The order of the market exemplifies 'the natural order'.

By individuals engaging in competitive market exchange, there is an inherent tendency for them to employ their labour and capital where it will produce the greatest wealth for themselves. Competition, it must be stressed, is seen as a critical factor in promoting the public interest. Through competitive exchange the aggregate wealth of society is maximised and economic growth occurs. Security of private property and, in order for exchange to remain voluntary, individual liberty, are viewed as being essential to the policy of income maximisation.

It would however be an oversimplification to argue that classical political economy, with its emphasis on wealth creation, had no regard for the well-being of the working class. On the contrary, Malthus maintained that, "*it is most desirable that the labouring classes should be well paid, for a much more important reason than any that can relate to wealth, namely the happiness of the great mass of society*" (cited in Gaus 1983, 185). This is not to say that the classical economists favour the suppression of the interests of other classes to further those of workers. On the contrary they resisted calls for legislation aimed to redistribute wealth such as progressive taxation or minimum wage levels. The *raison d'etre* of classical political economy was to provide a justification for policies that would benefit everyone - everyone as consumers - or in other words, the public. Concern with inequality was to the extent that policies aimed towards creating equality, whether social or spatial, must be such that the poor are made richer without making the rich poorer. In the subsequent development of neo-classical economics this policy became consistent with the concept of Pareto-optimality[3].

Although a certain amount of poor relief from public institutions was acceptable, issues of poverty were thought to be most appropriately dealt with by voluntary and religious organisations. Reliance on such bodies did not involve the levying of taxes to pay for public welfare which would have amounted to a coercive intrusion into the operation of the market. By funding poor relief through voluntary donation, the individual freedom and self-regulation of the market would be retained resulting in the securing of the public interest.

Another source of opposition from classical political economists to

wealth redistribution was the concern with the demographic trends of the time. Population growth rates in the 18th and first half of the 19th century in Europe were believed to be responsible for problems of scarcity of subsistence goods and overall resource depletion. The economist and demographer Thomas Malthus was influential in this respect. An important policy prescription arising from his general theory of population growth was that any redistribution of public wealth provided for the poor would ultimately be to the detriment of the poor, and so contrary to the public interest. The basis of this contention was that there would not be the same restraint on population growth as when individuals had to rely entirely on their own private resources to maintain their livelihoods. The reluctance of classical economists to countenance any public redistribution is echoed in some contemporary social theory as for example in the, *Tragedy of the Commons* by Hardin (1968) and in his subsequent work, *Life Boat Ethics, The Case Against Helping the Poor* (Hardin 1977).

Within classical political economy there is then an identity between the interests of the working class and the public interest where the latter is understood in terms of wealth creation, the existence of private property and market exchange. Within the context of the 1980s, it is possible therefore to see the basis of Lord King's claim that through privatisation, and the reestablishment of capitalism which it engenders, higher standards of living may be achieved. To this claim one may immediately add the qualification, higher standards of living <u>for some</u>. With the emphasis being placed on the operation of market exchange processes in ordering social life, it is perhaps not surprising that the role of the state in society was highly problematic within the classical tradition. This issue is addressed in the following section.

1.2.2 <u>The State and the Economy</u>:

A central argument of the classical school was that market exchange was a self regulating/equilibriating process and so any intervention by the state should be minimal as it would be detrimental to the process. Although the classical school presents the state, like the public, as being an aggregation of individuals (Cullis and Jones 1987, 42) there is a very important difference from the way in which the public is conceived. Rather than being the embodiment of all consumers or simply 'everyone' and thereby serving the public interest, the classical economists saw the state as being a political institution serving the interests of certain individuals only.

At the time the classical economists wrote, these certain individuals were typically merchants and manufacturers who had acquired political

power by which they could distort, to their own advantage, the operation of value exchange. In this case the pursuit of self interest was not seen as congruent with the concept of the public interest employed by the classical economists. The mercantilist state for most writers of this persuasion, but particularly Smith, was an institution that infringed upon individual liberty and served the private interests of those in power (political ends) rather than the public interest (economic ends).

The politically biased nature of the state was not the only concern of classical political economists. Albeit to varying degrees, they all maintained that holders of public office were not sufficiently knowledgeable of the public (consumer) demand to be able to decide what should most appropriately be produced. A further concern was that by virtue of their position in the state apparatus they would not have such a direct interest in the financial outcomes of their investment decisions. According to Torrens (1965), "*when works are carried on at the public expense, they are never performed so economically and well, as when carried on at the risk of private individuals, watching over the expenditure of their individual fortunes*" (Torrens 1965, 226 cited in Gaus 1983, 194).

Nevertheless the classical economists, particularly Thomas Malthus and J. S. Mill, recognised that private production and market exchange failed to provide certain goods and services that were in the public interest. In the light of this, Smith gives three duties of the state; defence, justice, and public works and institutions. The role of state activity is severly circumscribed as his focus of concern, along with other classical economists, was the mercantilist state and hence intervention by such a state could only be justified on the grounds of strict necessity or utility (O'Brien 1975, 273). The state might therefore supply certain goods and services but there is no conception of any public sector economy and therefore by extension no private sector economy.

On the whole classical political economists endorsed, albeit with limitations, the state development of major infrastructural projects like roads and canals in order to promote economic growth. A further recognition of the necessity of state regulation of the market was their belief that individuals pursuing their own private interests sometimes needed to be restrained in order to achieve the public interest. The "*appropriate framework*" which O'Brien (1975, 30) referred to above for ensuring optimal resource allocation involved not just the legal protection of private property but rather involved the implementation of health, safety, and fire regulations together with monetary, financial and banking regulations. Any advocation of a 'night watchman state'

restricted only to legislative and policing functions or of a rigid defence of a *laissez faire* economy can be said to have no place in classical political economy (O'Brien 1975, 272).

To summarise the argument so far, the critical issue in the classical perspective of private and public is that the two are conceptualised at the level of the individual. State intervention in the economy should be minimal and restricted only to cases of market failure. Classical political economy did not admit of any public or private sector economy. Rather society consisted of the state and the market, the latter being synonomous with 'the economy' the former with 'the political'. Private, individual interests pursued in the market place promote the public interest in the form of the greatest good, if not for all, then for the greatest number. On the other hand for those in power, that is in the state apparatus, the pursuit of individual interests then equates with private interests. There is, therefore, a divergence of interests in classical political economy between the public, conceptualised as 'everyone as consumers', and the state as a repository of private vested interests which comprise the sphere of politics. In broad terms, the state and the market and the political and the economic are antithetical to each other.

Towards the end of the 19th century however, there developed a growing realisation that the pursuit of self interest through unfettered market exchange was neither economically desirable nor politically sustainable. A different approach to economic organisation was required in order to promote the public good and social harmony.

1.3 Liberal Political Economy and the Development of the Public Sector Economy[4]

1.3.1 The Public Interest Redefined

The theoretical development of 'positive liberalism' (Fainstein and Fainstein 1980, 280) arose in the late 19th century and included, in the USA, New Deal and War on Poverty programmes with the intention being that, "*the harshness of the capitalist market system can be tempered through humane public action*" (Fainstein and Fainstein 1980, 280). In Britain the ideas of Fabian socialism started to became influential around this time and contributed to the formation of the Labour Party in 1901. The essential features of liberal political economy are twofold. First is that, as foreshadowed by some of the classical economists, particularly Malthus and Mill, market exchange between private individuals is not self equilibriating and therefore minimal state intervention does not promote the public interest. Second, the aggregative conception of the public is tempered, if not entirely replaced by, the introduction of a rather more

vague conception of the two which considers society to be a unitary whole.

Nevertheless the liberal political economists still retain a faith in the public interest being served by resource allocation through market exchange. There is also a similar, and even reinforced, concern for the well being of the working class and the differences between the two versions of political economy are more in degree than substance. Liberal theory tends to be much more qualified in the advocation of market forces than does classical theory while the former sees a much greater need for public concern over the well being of the working classes than does the latter.

Although classical economists recognised the massive inequalities generated by a market based economy with minimal state intervention, they deemed them to be a necessary cost of economic growth. Indeed only with economic growth could there be improvement in the conditions of the working class. Liberals on the other hand argued that such obsessions with wealth creation could compromise the development and welfare of all (Gaus 1983, 197) and not just the working class. As Beveridge wrote, "*misery generates hate*" (Beveridge 1944, 15 cited in Gaus 1983, 196) and so could seriously threaten the established order. Moreover the classical economists' argument that the market alone could create economic growth is open to question.

In the liberal view, the public interest is founded much more on the redistribution of wealth rather than solely on its production by the pursuit of (private) self interests. Instead of resource allocation through competitive market exchange, liberals advocate a certain degree of distribution through plan or organisation. It is generally maintained that rather than decreasing labour productivity, redistribution could, on the contrary, increase it. Whatever the effect on productivity, the liberal perspective would also cite the social need for planned redistribution as being the stimulus for 20th century growth of Weberian style bureaucracies with their particularly hierarchical means of achieving resource redistribution.

The changing demographic patterns in the 20th century meant that liberals were not so concerned with population growth pressing on resources if wealth redistribution took place between classes. According to Donnison (1984, 46), "*The arguments advanced by William Beveridge and others of his generation for national insurance and a national health service were as much concerned with the inefficiency of friendly societies, private insurance, and private and voluntary hospitals as with their inequity*".

In these cases private provision was inefficient, in as much as it was expensive compared to what the state could provide, and besides it was an inadequate service in terms of social need (Donnison 1984, 47).

For liberal political economists, the public interest is defined more in terms of pursuing policies designed to achieve social justice than aggregate wealth accumulation and they maintain that the market system alone is neither efficient in terms of labour productivity nor in terms of social justice. The natural justice of the market is therefore replaced by the social justice of redistribution and the public interest is at least supplemented, although not supplanted, by state welfare. Indeed some would argue that the latter should be achieved even if it conflicts with the former. There can therefore develop a necessary trade off between social equity and market efficiency. The different perspectives on the public interest which the two theories exhibit are presented in figure 1.3

FIGURE 1.3: The Public Interest in Classical and Liberal Political Economy

Classical Political Economy	Liberal Political Economy
Self Interest	Redistributive Justice
National Wealth	State Welfare
Market Efficiency	Social Equity

1.3.2 The State in Liberal Political Economy

One of the driving forces behind the development of a liberal political economy perspective according to Gaus (1983, 200) was the conviction that the classical world of individual capitalist entrepreneurs had given way to "*a system of powerful bureaucratic organisations able to defy the discipline of the market and whose individual decisions greatly affected the public welfare*". So the conception of a private sector as being based on individuals operating in an unregulated market changes to one of institutions acting in a distorted or 'rigged' market. But the critique of a market based economy is only a limited one. The policy prescription is simply to regulate the market and supplement it by public provision from the state rather than replace it altogether by another economic order.

Invoking the role of the state in the economy entailed a change in the conception of the state itself. A crucial factor in this change was the advent of universal adult male sufferage since then the state could be seen as a primarily democratic institution and which could consequently serve public (social) rather than private (individual) interests. The extent to

which the state is viewed as democratic has depended largely upon whether a pluralist or managerialist perspective is applied. In the former the state is assumed to be controlled by a plurality of different elected representatives, whereas in the latter case it is controlled by appointed managers (Johnston 1982, 22). The foundation of the pluralist perspective is that 'participation determines power' whereas in the managerialist case, 'power determines participation'. In both cases the liberal version of political economy open to attack from the classical view that the state remains the tool of private vested interests. In the pluralist variant "*the state is up for grabs*" (Saunders 1980, 32, cited in Johnston 1982, 22) by pressure groups or, in the managerialist case, is captured by managers and professionals who are seen to be immune from public recall or accountability.

The implication of these issues in respect of privatisation initiatives will be considered further in the next chapter. For the present, it is simply noted that neither perspective is very consistent with the liberal conception of the state as, "*the institutionalisation of the social whole and the guardian of the public interest*" (Gaus 1983, 205). There is however a third approach to analysing the state which is somewhat more consistent with the public interest as understood in liberal political economy.

In what has been termed the corporatist conception of the state, the disparate interests extant in both the state and the market place are seen to coalesce into a ruling triumvirate between the representatives of workers, employers and government. Collaboration between interests, whether public or private, replaces the bargaining, compromising and conspiracy of the pluralist and managerialist theses. In the pluralist perspective, policy is made by democratically elected representatives of the public while for managerialism it is made by appointed government officials. The corporatist framework on the other hand maintains that both representatives and officials from labour, business and government participate together in formulating public policy. For Jessop (1978), corporatism is:

> a system of representation in which capital [employers] and wage-labour [employees] are entitled to participate in the formulation and implementation of state intervention in the economy and in other matters relevant to capital accumulation [economic growth] (Jessop 1978, 41 cited in Johnston 1982, 122).

Within the corporatist framework, major decisions are made by government institutions outside of the elected parliament. But as Johnston (1982, 122) points out, an elected government is still needed to regulate

the action of, and sometimes to curb the excesses of, the corporate actors - whether of business, trade unions, or government bureaucracy. In this way the legitimacy of the economic system is preserved and the public interest is served accordingly. The corporatist view maintains that the state is an essential adjunct to the (capitalist) economy. The myriad of institutions through which the state regulates, plans and adjudicates, ensures that, in advanced capitalism, it plays a vital role in regulating and often organising production (industry) and consumption (welfare). The existence of 'enterprise zones' would be an important example of state support for industry while the enactment of protective labour legislation, such as minimum wage laws, is a prime example of the state playing a welfare role. Rather than the state being, an institution acting in a manner antithetical to the smooth operation of an otherwise free market economy as in classical political economy, it is instead an integral part of the economy itself.

For liberal political economy the dichotomy hypothesised in classical theory between the state and the economy or the political and the economic can still be maintained in analytical terms. At the empirical level however the liberal view gives recognition to a continuum between public and private sector institutions. Private individuals are still seen as operating in the market place but their significance is greatly overshadowed by large institutions both of the private and public sectors. Within the corporatist perspective, the state is assumed to have taken on many of the redistributional functions that for the classical economists would have been left to either market forces or, failing this, the voluntary sector.

The private sector of the economy, whether individually or institutionally conceptualised, is based in the market place while the public sector is regarded as coinciding with the activities of the state. In this way the state sector and the private sector together ensure that the public interest is served. By contrast with classical political economy, the state and market, as embodied respectively in the public and private sectors, are complementary to each other rather than antithetical.

To summarise, it may be said that in the liberal view of society, the private world of self interest, national wealth and market efficiency is amalgamated with the public world of redistributive justice, state welfare and social equity. Economic growth through market competition is still seen as being in the public interest but not to the exclusion of other social and political factors. Without the justice, welfare and equity that only a public sector economy can provide, the capitalist economy would be

inherently unstable. The liberal view on the significance of the public sector for securing the public interest is epitomised in the following quotation from the economist Frank Hahn cited in *The Economist*:

> It is likely that the vastly exaggerated claims for the invisible hand will lead to a reaction in which the hand, to our great loss, will be amputated forever (The Economist [London], May 6th 1989, page 63).

Nevertheless, as this quote makes clear, and to repeat if only for emphasis, the critique of classical political economy by the liberal version is only partial. The need for an invisible hand through market exchange and private ownership of property is still retained. For a more fundamental critique it is necessary to turn to the methods of Marxian political economy in which the concepts discussed thus far take on a very different complexion.

1.4 The State and the Market in Marxian Political Economy

The central focus of Marxian political economy is the role of social class forces in the development of capitalist society. For Marxian enquiry the classical concern with self interest and economic growth, and the liberal concern with social welfare and state redistribution, is replaced by an emphasis on class relations and capital accumulation. A further contrast with the previous two theories lies in the conception of the public interest.

The term 'the public' has been conceived of as being either an aggregate of individuals or a unified social whole. There is therefore an implicit blurring of the class divisions embodied in capitalist society. So instead of asking whether the public interest is served by the enactment of social processes, such as privatisation, the question posed in Marxian analysis is, whose class interests are served? A start may be made in answering this question by examining the social significance of the market and private property in the context of a specifically capitalist economy. This requires that the concepts discussed in previous sections are analysed within an historical context of societal development.

1.4.1 The Market and Private Property in Marxian Political Economy:

Long before the advent of capitalism, markets were established and competition between owners of capital, such as merchants and money lenders, set commodity prices and interest rates (Burkett 1986, 194). With the development of capitalism the vast majority of people became propertyless[5], to the extent that they no longer had possession of sufficient means of production to support themselves without recourse to wage-labour. At this stage a market developed specifically for buying and selling labour power[6] in which the workers' capacity to labour had to be

exchanged for a monetary wage. Without this market in labour power capitalist commodity production and market exchange could not exist.

The particular significance of the labour market for Marxian political economy is that, through the exchange process it engenders, workers produce more value than they collectively require to live on. The surplus value produced is appropriated by the property (ie means of production) owning capitalist class. By capitalists reinvesting this surplus value in further rounds of production, capital accumulation occurs, understood in classical and liberal political economy as economic growth. So rather than being simply a medium of free and fair value exchange, the capitalist labour market is also the site of exploitation between two classes; those who are propertyless (workers) and those who privately own property in the form of the means of production.

The existence of the market place in capitalism is inseparable from the development of private ownership of the means of production such as land, minerals, machinery and factories. With certain individuals acquiring these assets (ie property) and thereby making most people propertyless, the need arose for people to sell their labour power to the owners of property in order to survive. Without private property ownership there would be no labour market although this would by no means rule out the existence of other markets. Private ownership of property then is not merely a device that ensures the value exchange of all commodities. In the Marxian perspective it is more fundamentally the embodiment of a social relation between the owners and non-owners of property. These two classes meet in the market place by exchanging labour power for wages in order that production may occur and capital be accumulated.

Once the private ownership and value exchange of property became established the owners of property had neither to exert any political coercion over the workforce to ensure that they sold their labour power, nor did they have to perform any redistributive welfare function. This provided a distinct contrast to pre-capitalist societies where holders of economic power also held political power. Under capitalism however all production became effectively privatised while all redistribution and coercion assumed a distinctly public or social dimension. In other words, the private or economic sphere of production became divorced from the public or political sphere of redistribution and the public aspect of social life became the sole prerogative of the state apparatus (Wood 1981). To the extent that the process of value exchange fails to secure the on going reproduction of both labour and capital, there is a requirement for a

degree of public redistribution of surplus value and this requires the existence of certain state (public) institutions.

1.4.2 The State in Marxian Political Economy

It has been seen that both classical and liberal political economy conceptualise the state in terms of it having certain functional characteristics according to the way in which it is deemed to serve the public interest. By contrast, Marxian theory is concerned with deriving the particular form and function of the state from the operation of capitalist social relations. The task is by no means straight forward and indeed the Marxian literature on the state is about as vast as it is contentious. Within contemporary accounts of the capitalist state possibly the most widely accepted are those presented in Offe (1984).

The work of Offe has arisen largely from a critique of earlier Marxist 'instrumental' theories, in which the state is conceived of as being an instrument for promoting the common interests of the capitalist class (Offe 1984, 119). The instrumentalist theories, exemplified in the writings of Miliband (1969), did themelves arise as a critique of the pluralist perspective in which the state acts for the common good of all through the operation of democratic structures (eg voting procedures). Offe maintains instead that the state, "*seeks to implement and guarantee the collective interests of all members of a class society dominated by capital*" (Offe 1984, 120 emphasis in original).

For the state to guarantee those collective interests or more generally to carry out political functions, it depends critically upon the tax revenue generated by the volume of private capital accumulation. At the same time however the state cannot organise and control the accumulation process without violating the *modus operandi* of capitalism with is foundations in private ownership. State (ie political) power therefore depends on a process of accumulation which is beyond its power to organise. A consequence of this, Offe (1984, 120) maintains, is that "*every occupant of state power is basically interested in promoting those political conditions most conducive to private accumulation*".

So while the capitalist class is not able to subjugate the state apparatus entirely to suit its requirements, as in the crude instrumentalist theory, Offe argues that "*state actors must be interested - for the sake of their own power - in guaranteeing and safeguarding a 'healthy' accumulation process*" (Offe 1984, 120) which in turn requires the maintenance of the class relations underpinning capitalism. Failure to do so inevitably results in the replacement of that regime by one more conducive to capital accumulation. Upon this basis privatisation may be

seen as a means to achieving a "*healthy accumulation*" process and to reinforcing capitalist class relations.

The capitalist state therefore has a contradictory social function. It depends for its existence upon a process over which it has no control and which runs counter to the exercising of state power (Giddens 1984, 315). But as already seen commodity production by private interests does itself demand a degree of collective production by public (state) institutions, typically in the form of major infrastructure investment and basic welfare provision. At the same time however the collective provision serves to destroy the commodity form upon which capital accumulation, and ultimately the state itself, is dependent upon. Based on Offe (1984), Giddens (1984, 315), argues that, "*the contradictory nature of the capitalist state is expressed in the push and pull between commodification, decommodification and recommodification*".

This is illustrated by Giddens with the examples of public health care and transport provision. By socialising these services they no longer take the commodity form and are provided according to a perceived overall need of capitalist production rather than the ability to generate private profit for any individual capitalist. Those with the highest income tend to have the least need for public provision of these services as they can opt for privately provided ones. Because of graduated taxation scales, such people have often had to contribute a disproportionate amount towards the maintenance of public provision. This situation though has been altered considerably in some Western countries during the 1980s with the coming to power of more politically conservative governments. The point remains, however, that higher tax paying people are likely to apply pressure to have public services recommodified or, in other words, (re)privatised. Giddens (1984, 316) concludes that as those who are on lower incomes are likely to have opposing views, government policy may vacillate between socialisation and privatisation according to the class interests of the political party in government.

The important point from a Marxian perspective on privatisation is that the process represents a drive to reassert capitalist class relations and thereby intensify the exploitation of labour power. The state provision of decommodified public services is seen as part of the social wage paid from taxation on both workers wages and capitalists' profits. Any reduction of the social wage through privatising the state represents a greater exploitation of labour. Instead of attempting to reinforce the commodity form, as in classical theory, or merely to reform it, as in liberal theory, the prescriptive basis of Marxian theory is ultimately to

eliminate the commodity form. This requires the ending of private ownership of the means of production and therefore of capitalist class relations and their replacement by a completely different socio-economic order of comprehensive collective production.

Summary and Conclusion:

The discussion in this chapter has attempted to show that, regardless of how privatisation is defined, any analysis of the process itself will vary enormously according to the theory of political economy that is applied to the fundamental concepts involved. The critical differences are summarised in tabulated form (figure 1.4). Any explanatory frameworks developed to show why the process of privatisation may be implemented will clearly depend critically upon whether the concepts involved are analysed from the standpoint of individual actors, institutional organisations or class conflicts in material production.

FIGURE 1.4: Socio-Economic Concepts and Political Economy

Political Economy	Private Sector	Market Exchange	Public Sector	State Functions
Classical	Individuals	The economy	Aggregation 'everyone'	Private Interests
Liberal	Institutions	Sector of the economy	Society	Public Interest
Marxist	Social Relations	Site of Exploitation	Class Structure	Contradictory

Between the classical and liberal approaches to privatisation there are distinct differences in the structures that are established. A market economy founded on individual actions is counterposed to one in which institutions are the prime actors. Similarly an autocratic state apparatus is contrasted to an essentially democratic one. Within the terms of classical political economy, privatisation would be conceived of as being a transference from provision and control by a state apparatus serving private interests alone to one of individuals operating freely in a market economy. The assumed freedom of individualism is counterposed to the assumed coercion of collectivism. Privatisation is therefore seen as a policy that serves the public good (interest). By contrast liberal political economy sees privatisation as a transference from a democratically founded state which serves the public good to private institutions that, for liberals, are often seen to be beyond public recall. In this way there is a failure to achieve the public good primarily because

the concept is understood differently from that of classical political economy. Rather than being in the public interest, privatisation is then viewed as serving private interests.

In the Marxian view the focus is on social processes rather than structures. Changing class relations are the critical explanatory variables. Whether serving public or private interests, privatisation is a process for reinforcing capitalist class relations. The Marxian perspective on privatisation, and its contrast with the other two formulations, may be presented by paraphrasing Roemer (1986, 152) thus:

> When (neo) classical economists argue for privatisation to increase economic growth, the liberal economist can only reply that privatisation does not achieve this end. Marxists on the other hand might admit that privatisation will increase economic growth, understood in the form of capital accumulation, but take this not as a mandate to privatise but rather as an indictment of the system of property relations in which such forms of productivity stimulus are needed.

As capitalist production requires both private accumulation and social redistribution, the process of privatisation is at the same time a contradictory one which is beset by class conflict. To return to Lord King and his view of privatisation, the liberal opponent would strongly deny that privatisation leads to 'better ways of working and higher living standards' and may even be detrimental to economic growth. Marxists, however, might see Lord King as being right in as much as privatisation involves the 'reestablishment of capitalism'. But the 'better ways of working' are based on a greater degrees of labour (class) exploitation while the higher standards of living that acrue to some sectors of society may mask ever greater socio-inequalities.

From the three frameworks of political economy presented here, the process of privatisation can have very different conceptual foundations. It is from these very foundations however that explanations for why the process has occurred may be offered and, more particularly from a geographical standpoint, why privatisation has developed unevenly across both space and time. This subject forms the basis of the next chapter.

Footnotes:

1 The discussion in this and the subsequent section owes much to Gaus (1983).

2 Most noteable amongst the classical political economists were, Adam Smith (1723-90), David Ricardo (1772-1823), Thomas Malthus (1766-1834), John Stuart Mill (1806-73), and Jean Baptiste Say (1767-1832).

3 Pareto, Vilfredo Federico Damaso (1848-1923), Italian economist.

4 Amongst the founding members of the liberal tradition are, Sidney Webb (1859-1947), Beatrice Webb (1858-1943), William Beveridge (1879-1963) and Herbert Morrison (1888-1965).

5 The term 'propertyless' refers specifically to the lack of ownership of productive assets or means of production. It is fully recognised that private ownership of the means of consumption (eg home ownership) is widespread in many capitalist (and socialist) economies.

6 The term labour power is used to indicate that under capitalism workers only sell their capacity or potential to work rather than their complete *personna* as in slave and feudal societies.

CHAPTER 2

Theoretical Perspectives on the Development of Privatisation 1: Public Choice and Managerialism

The previous chapter analysed the different approaches to political economy that underlie concepts commonly used in definitions of privatisation. From the discussion it was seen that any understanding of privatisation would depend critically upon the way in which the terms private and public, market and state were understood. These concepts were examined in relation to the different analytical frameworks of political economy that have already been established - classical, liberal and Marxian. This chapter builds upon these analytical foundations in order to develop possible theoretical explanations for the implementation of privatisation policies within a geographical context.

A cursory observation of privatisation policies, both within and between nation states, would reveal that they may be implemented at local, regional and national levels. Explanatory frameworks are needed therefore to account for any spatial and temporal unevenness in the development of privatisation at any of these scales. The chapter is presented in three parts. The first part briefly discusses the relationship between the productive and redistributive areas of state sector activity in relation to the geographical scale at which privatisation may occur.

This is followed by two sections which examine, in turn, two of the three main theoretical perspectives used within geography and which could be used to explain the development of privatisation: public choice theory of neo-classical economics; and Weberian organisational theory upon which the liberalist urban managerialist approach is founded. Discussion of the Marxian perspective is delayed to the following chapter. The shortcomings of the first two theories are presented and a need is demonstrated for a more comprehensive theoretical framework to advance understanding of the uneven spatiality of privatisation.

2.1 Privatisation and Geographical Scale:

In a comprehensive review of the varying extent of privatisation in Europe, Vickers and Wright (1988) argue that it is not easy to explain why policies to encourage privatisation are implemented for at least five reasons. First, there has been no systematic exposé of the reasons for privatisation; second, motives vary widely across European countries; third, emphasis is given to different objectives at different times; fourth, reasons for privatisation have often followed rather than preceeded its implementation; and finally, unspoken motives may not always be

distinguishable from the declared reasons or the consequences from the wishes (Vickers and Wright 1988, 5). Although their work is targeted at what they call industrial privatisation, which refers to the productive side of the economy, the reasons they cite could be just as applicable to the privatisation of the redistributive side of the economy which exists in the specific form of the welfare state.

Within a geographical context there are, in effect, two questions to address. First is why has the state sector been privatised and second, why has privatisation occurred so unevenly across space? Geographically uneven privatisation may occur at two principal spatial scales: the national and the local or regional. At the former level are state owned industries in the productive or trading sector of economies: industries such as steel production, mineral extraction, railways, posts and telecommunications. Some of these first became established as private ventures in the 19th century before their gradual assimilation into public ownership in the 20th century. In the 1980s however some of these industries have been returned to private ownership in certain countries. The geographical variations in the extent to which this has occurred allows for comparisons on an international scale as attempted in a descriptive manner by Vickers and Wright (1988) within Western Europe.

At a regional or local level the state provides services aimed primarily, but not entirely, at redistribution rather than production. Typical examples are urban passenger transport, public utilities, schools, hospitals and social welfare payment offices. Although almost always provided under conditions laid down by the central state their administration is generally conducted at various sub-national levels. In these cases there is scope for the privatisation of these services to develop unevenly within a specific national context. The spatiality of their privatisation can then be examined within both a national and international context.

A further important distinction can be made between privatisation at the national and subnational levels. In the former case, privatisation policies have generally been applied to complete industries. For example, where electricity generation, airlines and telecommunications have been privatised, the whole industry has usually been transferred to the private sector by means of a change in ownership rights. It should be emphasised that this is by no means always the case as will be seen in a later chapter. By contrast, however, at the subnational level privatisation has seldom involved changes to the ownership rights of entire organisations. Instead there has been a change to the form of service provision as certain

services start to be provided by the private sector. In the case of public hospitals, for example, state ownership of the institution is retained, while individual services can be privatised through having their provision undertaken by private sector operators. Subnational privatisation then usually only involves certain services within organisations being privately provided rather than the entire organisation itself being transferred to the private sector as often occurs at the national level.

The distribution of resources, whether publicly or privately owned, has long been a preoccupation of geographers. To date however little attention seems to have been given to variations in the extent to which transfers from public to private provision have occurred regardless of the geographical scale involved. In attempting to provide an explanatory basis for spatially uneven privatisation, the three main theoretical perspectives used in geography to explain resource distribution may be applied; public choice, managerialist, and Marxist. The remainder of this chapter critically evaluates these theories with this end in mind.

2.2 Public Choice Theory and Privatisation:

According to this theory, the public or state sector of the economy should, wherever possible, replicate the operations of the market as in the private sector, where, it is claimed, individuals are able to exercise freedom of choice. The state apparatus at both local and national level has both a bureaucratic arm, comprising appointed managers or bureaucrats, and a democratic arm of elected presentatives of the community or the nation. In public choice theory, state sector industries and institutions (bureaucracies) are seen as monopolistic and therefore denying the consumers of their goods and services the choice that would be offered them in a competitive market environment. Public provision of goods and services becomes inherently problematic as it conflicts with the public interest secured through market exchange. Within public choice theory there is therefore an extensive critique of state sector activity which is elaborated upon in the following section.

2.2.1 Economic Efficiency, Property Rights and Privatisation:

Where collective provision obtains, as in the state sector, public choice theory argues that managers pursue their own private interests rather than the public interest. They can do this because, as the previous chapter showed, the state sector economy does not operate according to value exchange criteria. For this reason it is deemed to be permanently prone to economic inefficiency and therefore operates contrary to the public interest. The pursuit of economic efficiency lies at the very

heart of arguments for privatisation and it has two principal aspects to it:

1 Productive efficiency is realised when goods and services are produced with minimal cost in resource utilisation. In quantitative terms productive efficiency is simply the ratio of output to input costs. The ratio is maximised when input costs are minimised for a given unit of output. Even where production conditions enable this ratio to be maximised there can still be an inefficient allocation of goods and services if more, or less, is produced than is required by society. Productive efficiency does not necessarily imply allocative efficiency.

2 Allocative efficiency is realised when the allocation of resources in society is such that the maximum possible social wealth is realised. In other words, an optimal allocative efficiency results when no one can be made better off without making anyone worse off - the so-called Pareto criteria. Where there is allocative inefficiency there are still opportunities to increase social wealth by reallocating resources without making anyone else worse off.

The conditions for satisfying allocative efficiency are automatically fulfilled when individuals pursue their own self interest in a perfectly competitive market by maximising profits, in the case of firms, and utility, in the case of consumers (Stephens and Nolan 1988, 59). Leibenstein (1966) has termed as *X* inefficiency, the difference between the maximum possible economic efficiency attainable for a given input and the actually existing level of efficiency in an institution. Most public choice theorists argue that, largely due to the lack of market competition, state sector institutions, have a greater level of *X* inefficiency than private sector ones.

If the existence of value exchange is a prerequisite for attaining maximum economic efficiency, there must also be a clear establishment of individual rights to private ownership of property in order to realise value exchange. Within the ambit of public choice theory has arisen, since the late 1960s, a fairly extensive literature in the so called 'Property Rights School' with major contributions coming from Demsetz (1967) and the writings in Furubotn and Pejovich (1974). The main argument, as Hodgson (1988, 152) explains, is that:

> by providing individual incentives and disincentives in the form of property rights in areas hitherto uncovered it is imagined that the scope for government intervention would be reduced and individuals would be more free to assess benefits and disbenefits on their own and act accordingly.

Rather than have problems such as air pollution or workplace safety

controlled by government intervention, it is maintained instead that the solution lies in developing and enforcing a system of clearly defined property rights, so that aggrieved parties could sue those responsible for their disadvantageous situation. The policy implications of this school of thought is that if property rights are not unambiguously defined resources will not be correctly valued (ie priced). Where property rights are held collectively, resource allocation is thought to be inefficient since each individual can gain full use of the resource without paying for the full cost of it. Alternatively stated there is no incentive for individuals to achieve economic efficiency. Hence there is potential for waste with the ever present possibility for a 'Tragedy of the Commons' type situation referred to in the previous chapter.

Essential to the establishment of property rights is the requirement that they are embedded in a competitive market. This enables them to be transferred and traded between individuals or groups according to their most profitable outcome. The central argument for privatisation in terms of public choice theory is that private sector enterprises with clearly defined rights to profit will perform better (ie be more efficient) than those in the state sector where rights are diffused and uncertain (Dunsire et al 1988, 365).

One of the claims of some public choice theorists such as Parkinson (1958) and Downs (1967) is that state institutions have an in-built tendency towards continual expansion (Jonsson 1985). This contention was extended by Niskanen (1971) who claimed that state sector managers (bureaucrats) necessarily strive to maximise their budgets and oversupply their services or outputs. Because of ill-defined property rights, public bureaucracies are forever prone to oversupply outputs - that is to supply to a level beyond which is socially optimal as judged by a perfectly competitive market. The implication is that the state sector will always be allocatively inefficient regardless of how internally or productively efficient it may be.

The growth of state sector expenditure is, in public choice theory, primarily a consequence of this maximisation hypothesis. Through not being exposed to the discipline of market forces and the need for commercial profitability, managers can push for ever greater budgets to increase their numbers, improve promotion prospects and all round job security. A monopolisation of knowledge and lack of public recall or accountability accompanies this process. The immediate policy prescription is privatisation of the institution (bureaucracy) either through its sale or contracting out to the private sector. While this maximisation thesis

is by no means uncritically accepted even amongst public choice theorists themselves (see Lane 1987, ch1,) its significance lies in the unequivocal rationale it provides for privatisation.

Whether the maximisation thesis is accepted or otherwise, most public choice theorists argue that state sector bureaucracies have expanded to the extent that private profitability and public choice has been severely compromised. As the state sector bureaucracies expand their activities through, say, taking over the ownership of bankrupt private companies and extending social welfare provision, there is a 'crowding out' of the (productive) private sector (Bacon and Eltis 1978). The tax base is consequently eroded which gives a reduced supply of resources for the state to redistribute, while at the same there is an increased demand for state provided goods and services. The obvious remedy of raising tax rates, while perhaps providing temporary amelioration of the situation, only places a still greater tax burden on the existing private sector. Ultimately then the need for privatisation in public choice theory rests on the operation of supply and demand factors.

Within the field of public choice theory two distinct approaches to the provision of state sector goods and services can be identified. The public economy variant attempts to construct a "*representative theory of democracy based primarily upon* [value] *exchange relationships in society*" (Clark and Dear 1984, 47). The other approach - the pluralist variant - is founded on the contention that the public interest is served by, "*politicians reflecting the preferences of voters through their responses to the demands made by pressure and interest groups in a pluralist society composed of many complex groups*" (Pinch 1985, 34). In the next two sections these two variant forms, starting with the public economy one, are discussed in respect of their ability to explain the implementation of privatisation policies, while a third section focuses on their distinct geographical context.

2.2.2 The Public Economy and Public Choice Theory:

The origins of the public economy approach to the state sector extends back to the classical economist J.S. Mill in his *Principles of Political Economy*. It was not until the 1950s that it became widely used to analyse the provision of local government services. The most important theoretical contributions have been due to Tiebout (1956) and Downs (1957), and much subsequent geographical work in this field is considerably indebted to these two writers (eg Bish 1971 and Bish and Ostrom 1976). In simplest terms, the intention of the public economy approach is to apply micro-economic analysis to the supply of publicly provided goods and

services. The solution to the 'problem' of state sector oversupply propounded by Tiebout is to establish numerous small local authorities supplying a varying number of public services in direct proportion to the level of local tax.

Residents could choose which particular mixture of services and taxes they desired by opting to migrate to the authority most suited to their preferences. In this way any oversupply of services would be met by higher than needed taxes which would result in out-migration and hence an erosion of the tax base. Public service cutbacks to a more socially optimum level should then follow. The state supply authorities would thereby receive price signals just as if they were operating in the market place. Consumers become the equivalent of voters (ie consumer voters), but voting with their feet rather than through the ballot box. Using the terminology of Hirschman (1970) this is the equivalent of the 'exit' option that is open to people when faced with a problem. The desired policy outcome is a series of local authorities competing with each other to gain residents and capital investment, just as private businesses compete with each other in the market place for customers.

The Tieboutian model, since it is an ideal model, has a number of restrictive assumptions, such as all individuals having perfect mobility and sufficient resources to undertake the necessary migration. This aside there is some empirical evidence from both the USA and the UK to support the hypothesis of voting with ones feet in response to high taxation and diminishing levels of service provision. In an empirical test of Tiebout's hypothesis, Aronson (1974) has applied mathematical modelling to population movements in selected metropolitan areas. Taking Harrisburg (USA) and Leeds and Manchester (UK) as case studies, the conclusion was that fiscal factors appear to have affected the distribution of population in all three areas although the trend was more pronounced in the US example than in the UK (Aronson 1974, 338). A few years earlier Oates (1969) in study of tax rates and public service provision in the New York metropolitan region found empirical support for Tiebout's model while more recently Davies (1982) came to similar conclusions in a study of 'fiscal migration' between the boroughs of metropolitan London.

These cases notwithstanding such analyses have been subjected to much criticism. A comprehensive critique of the theoretical approach has come from Clark (1981) who, writing from a broadly Marxian perspective, maintains that, "*those elements central to any critical analysis of capitalist democracy, class conflict, the mode of production, ideology, and the state are missing from Downs and Tiebout*" (Clark 1981, 120). It is

not necessary however to appeal to Marxian methodology to criticise Tiebout and Downs.

There is no denying that people's choice of destination may be influenced, in part at least, by tax and service levels. Nevertheless much of the literature on residential relocation cites changes in life cycle and socio-economic status as being more important factors in determining peoples migratory tendencies than the balance between property tax and service provision (Pinch 1985, 34). Another limitation of the Tieboutian model is that it ignores both certain groups income constraints and the impossiblity of achieving many scale economies of service delivery in a spatially fragmented administrative system. In view of the restrictions that apply to the public economy approach, Pinch (1985, 34) argues that it has been less influential than the pluralist approach.

2.2.3 Political Pluralism and Public Choice Theory:

The original works in this approach can be attibuted to Dahl (1956) and Polsby (1963) while Shelley (1984) has reviewed much of the contemporary writing. A fundamental premise of the pluralist approach is that consumer preference or public choice is revealed through democratic voting procedures. In this case voting is through the ballot box rather than with the feet. As stated briefly above, under pluralist democracies, policy makers have to respond to various interest and pressure groups. In order to stay in political office they would most likely respond to the group which takes the most political action to have its concerns aired. For indivdual and group interests, the pluralist principle is basically that, 'the door that squeaks gets the grease'.

The extent to which political action occurs is expected to reflect the strength of the group preference and therefore the public interest. If people should fail to be represented in such a democratic arrangement the system gives them a clear signal to improve their ability to be heard in the political arena. Moreover should there be any abuse of power by an elected representative s/he can always be recalled from office through periodic elections. Appealing again to the terminology of Hirschman (1970), the pluralist approach is predicated upon people taking the 'voice' rather than the 'exit' option. An important part to the pluralist model is that the state apparatus itself is perceived to be a neutral arbitrator between competing groups and therefore not beholden to any sectional or class interests. Any discriminatory actions on the part of excessively strong pressure groups would not be countenanced by the holders of political power and so the overall public interest would not be compromised.

With reference to the privatisation of either nationalised industries or urban services, pluralist public choice theory sees the policy as reflecting consumer preferences revealed in the outcome of electoral processes. Sears and Citron (1982, 1) give several examples to reveal the explanatory power of pluralist public choice theory. They cite the electoral successes of Right wing parties, since the late 1970s, in the Scandinavian countries, Britain, and the USA all of which were pledged to curb the economic activities of the state sector while promoting the growth of private enterprise.

At a more analytical level, studies by Johnston (1979 ch6) and Shelley and Goodchild (1983) have examined the levels of public provision in relation to partisan elections in a similar manner to those undertaken in modelling Tiebout's hypotheis. Possibly the most celebrated example of political 'voice' and tax/service levels has been the passing of Proposition 13 in California in 1978, as a consequence of a mass tax revolt by property owners. The effect of this was to reduce sharply property based taxes and to restrict their future growth (Sears and Citron 1982, 2).

The 'voice' option can also operate in the other direction insofar as it may be effective in preserving, rather than reducing, state services. The long running and ultimately successful public campaign to keep open the Settle - Carlisle railway in Britain is an interesting example of this. Another example, which comes close to the ridiculous, concerns what *The Economist* of London has refered to as, "*the controversial Right-wing leader of Westminster Council*". According to the *The Economist* (1989, 54):

> [the leader's] obsession with privatisation has got her into deep trouble. Eager to get rid of a loss-maker, in 1987 she pushed through the sale of three council-owned cemeteries to a property company for 15 pence.
> A public outcry has forced the council to agree to buy them back, though the asking price is now closer to £10M. The fiasco has fuelled Tory worries that her public image might be a liability.

The important point about both the public economy and the pluralist variant of public choice theory is that they each assume an equal ability of individuals to influence policy outcomes. Peoples' ability to participate in electoral campaigning or house moving can be severely constrained by their lack of finance and material resources. Notwithstanding these limitations it is the public economy approach, based on the Tieboutian hypothesis, which seems to have most prescriptive potential in respect of privatisation.

The democratic pluralist model of state provision is open to the public choice objection of the ever present possibility of corruption and

'pork barrelling' in which case consumer preferences are not realistically represented. Market oriented structures, such as Tiebout's are preferred, on the grounds that, as Friedman and Friedman (1960) first argued, a vote 'through the pocket' or 'by the feet' is a more reliable indicator of preferences than a vote through the ballot box. Through the *de facto*, if not *de jure*, establishment of property rights in state service provision, local authorities have to compete with each other for consumers' tax revenues. For privatisation at the national level, public choice theory would advocate the spatial fragmentation of enterprises so as to promote competition between them and hence promote consumer (public) choice.

The establishment of a market exchange process for goods and service provision should mean that state sector managers will no longer have a vested interest in maximising their budgets, and oversupplying services beyond the level of consumer preferences. In achieving this end contract, rather than direct, employment is generally preferred together with multiple-provider structures over single provider structures (Hood 1987, 149). Under these circumstances not only would service provision be spatially fragmented but conditions of employment become 'individualised' with the implementation of contracts. In this way employment conditions more accurately reflect market conditions and so they are in effect, 'privatised', just as is the service provision itself. A crucial aspect of privatisation policies is the necessity to fragment production into several competing enterprises and thereby ensure public choice.

In order to present such policies in an historical context it is worth noting that in 19th century USA, urban public transport was predominantly privately owned and highly fragmented into a multitude of enterprises competing over different routes. One of the reasons for the increasing degree of state provision of urban transport in the 20th century was to introduce some rationalisation to the route structure (Stopher 1988, 22). Also, according to Stopher (1988, 22), "*cut throat competition among operating companies was increasingly responsible for degradation of service*" from which he concludes that those advocating privatisation policies that spatially fragment production would rather repeat history than learn from it.

2.2.4 The Spatiality of Privatisation and Public Choice Theory

Although many geographical applications of public choice theory exist there has not hitherto been much attention given to spatial unevenness in the privatisation of public services. Reynolds (1976) has analysed the variation within, and between, three metropolitan areas of the USA (Los Angeles, St Louis, and Detroit) in their forms of public service provision.

Considerable attention was given by Reynolds to the extent of inter-government contracting for services, especially in Los Angeles, but he had little to say on the level of private sector involvement in the process in any of these conurbations.

Dunleavy (1986a) has shown that one major problem for advocates of privatisation based on public choice theory is that government bureaucrats, on the basis of their budget maximising tendencies, would be most reluctant to privatise the services they have control over. This would entail a reduction in their budgets, domain of control, and possibly job security. It is difficult to see how any impetus for privatisation would arise from within the bureaucracy itself. External pressure would need to be applied which, within the pluralist model of public choice theory, would come from the elected politicians. Within elected governments politicians may gain popular support for privatisation policies through presenting a tax-service provision trade off as in the case of California's Propostion 13 cited above.

Viewed in a spatial context it might be expected that privatisation could develop unevenly according to two principal factors. First, is the regionally varying electoral support for such a policy while second, would be the varying strengths of resistance from within the bureaucracies themselves. A further factor that should have a critical bearing on policy outcomes is the spatial variations in the level of pressure group interests for the maintenance of publicly provided services faced with the threat of privatisation.

Both versions of public choice theory could also be applied to the workforce employed by the state sector in the provision of goods and services. Faced with the prospect of privatisation and the likely reduction in employment conditions, workers have two options. Either the option of leaving (the Tieboutian solution - exit) may be adopted or of making representations to the public administration concerned that privatisation is not in the public interest (the pluralist solution - voice). To this end regional variations in the strength of workers convictions on privatisation and the conditions of the local labour market for alternative employment opportunities, could have a significant influence on the uneven development of the policy.

Regardless of whatever empirical validity could be found to support a public choice explanation of privatisation this would indeed only be a partial explanation. The public choice model almost totally ignores the role of private (institutional) investors, their preferences and their impact upon any privatisation initiatives. The theoretical framework seeks

to present a situation moving to a static equilibrium between supply and demand for goods and services. Little is said in relation to any of the broader socio-economic forces that might lead to a change in consumer preferences towards (or even against) privatisation or which place the state under severe constraints in the field of service provision. Taking this into account, along with Dunleavy's (1986a) criticism of public choice theory cited above, it becomes clear that other theoretical frameworks must also be considered in order to obtain a broader explanation of privatisation.

2.3 Managerialism and Privatisation:

The managerialist framework for explaining the distributional aspects of public goods and service provision, whether publicly or privately provided, was born largely of a dissatisfaction with the public choice theory of seeking optimal social allocation of resources based on market criteria. By contrast with public choice theories of (state) bureaucracy which tend to be, according to Lane (1987, 2), "*individualist, atomistic and economic in their assumption*", the organisational theory upon which the managerialist framework is founded, displays a preference for "*structure, holism and power*" (Lane 1987, 2). In the latter, society is ruled by appointed managers (bureaucrats) rather than by democratically elected politicians.

In this respect managerialism is not at variance with the public economy (Tieboutian) version of public choice theory, but the prescriptive implications for privatisation are quite different as will be seen presently. The intellectual origins of managerialism can be traced back to Max Weber rather than Adam Smith or J. S. Mill. In terms of political economy the analytical approach adopted by the managerialist framework is much more liberal than classical. The public interest and the perspective on privatisation are therefore seen very differently in the two cases.

2.3.1 The Weberian Origins of Managerialism

For Weber the development of bureaucracy has been a necessary accompaniment to advanced capitalism by imparting to it a level of organisation and stability thought to be lacking in the market place. He maintained that political domination in modern capitalist society necessarily and increasingly becomes bureaucratic. Instead of being inherently inefficient, bureaucracies, whether private or public, are instead seen as being, potentially at least, highly efficient. The discreprancy between the two theories lies largely in the different conceptions of efficiency employed. Weber (1978, 223) argued that:

> [B]ureaucracy is, from a purely technical point of view, capable of attaining the highest degree of efficiency and is in this sense formally the most rational known means of exercising authority over human beings (cited in Lane 1987, 3).

The important point is that Weber contrasted modern bureaucracy under capitalism with traditional pre-capitalist feudal and oriental forms of bureaucracy. He found in favour of the efficiency of the former but this finding was set in terms of organisational form rather than economic efficiency. By organisational form Weber meant the rigid rules and codified conduct of modern bureaucracies. These characteristics served to minimise the nepotism and political patronage so endemic to earlier forms of bureaucracy. More particularly, Weber saw bureaucracy as being efficient insofar as it was a rational means of organising production.

The concept of rationality in organisational theory has been identified as, "*the capacity of organisations to order and to make sense of complicated environments*" (Meyer 1987, 215). Studies of bureaucracy subsequent to Weber have produced the concept of 'bounded' (ie limited) human rationality which, "*compels construction of organisation to accomplish complex tasks*" (Meyer 1987, 221). Bureaucracies in organisational theory may, or may not be economically efficient, but they are inherently rational. They bring order and reason where otherwise choas and systemic breakdown would occur. Public sector policies may therefore be analysed from the perspective of economic efficiency or bureaucratic rationalisation'.

A further issue of dispute between public choice and organisational theory is the motivational factor of individuals. As already seen the former theory focuses on maximisation borne of self interest; state sector managers maximise their budgets, and individuals in the market place maximise their profit. The latter theory however argues that bureaucrats, whether in public institutions or private enterprises, do not 'maximise' but 'satisfice' because there are cognitive limits to human choice (Stephens and Nolan 1988, 61). Particularly in the case of senior public sector managers, Stephens and Nolan (1988, 61) maintain that the desire for job satisfaction and serving the community is more readily identified as the motivational factor rather than maximisation.

Within the managerialist framework, managers can be seen as being able to serve the public interest, at least insofar as the concept is understood in liberal political economy. The pursuit of both efficiency and equity are much more compatible than in public choice theory. But organisational theorists going back to Weber himself have had many

misgivings over the enormous political power of bureaucracies and the managers who staffed them. An important feature of Weber's model of bureaucracy was that the exercise of power, authority and domination was based on knowledge. In short, knowledge is power. Upon this basis exists an extensive role for a professional salariat within the bureaucracy, who without owning any productive assets unlike the capitalist class, have class interests quite distinct from wage earners in the work force.

The class power of the 'professional, technical and managerial strata' (PTMS), which may exist in both the private and public sector, arises through an ability to restrict entry to their positions on account of their knowledge and the necessity of formal qualifications. They can therefore obtain political power quite independently of any economic power through ownership or control of productive assets and, moreover, their political power is removed from any democratic control. According to Leonard (1982, 192), "*The increasing rationalisation of administration, thus reduces the possiblity of effective political control over the state bureaucracy for such control is only possible in a very limited degree to persons who are not technical specialists*".

While Weber saw a rationality for the existence of bureaucracy and its positive role in serving the public interest, he was nonetheless very ambivalent over its effects on both the individuals within it and society at large. He fully recognised the existence of many features of bureaucracy that public choice theorists have seized upon such as excessive secrecy, monopolisation of knowledge and lack of accountability. It is somewhat paradoxical therefore that while public choice theory is based largely on a critique of Weber's concept of bureaucracy (see Lane 1987, Hood 1987), managerialism, with its Weberian origins, arose as a critique of public choice theory.

2.3.2 Geographical Applications of Managerialism:

The first introduction of Weberian ideas into geography came with Rex and Moore (1967) in their study of housing allocation in Britain. Like public choice theorists, they also saw the spatial structure of urban environments as reflecting a migratory process from (city) centre to (suburban) periphery. The crucial difference is that Rex and Moore did not analyse this as a market driven process, as in the Tieboutian model, but rather as a class mediated process. Class status in the market place (ie wealth) considerably enhances a person's opportunity to move to different parts of the metropolis in accordance with their perceptions of service quality. To the extent that spacious housing in the suburbs was desired by all, it is a scarce resource which is unequally distributed

amongst classes hence there is potential for political conflict that market forces cannot transcend.

Two important factors which mediate the operation of the market were identified by Rex and Moore. First, was the security and size of the income of residents as this determined how banks and building societies would allocate credit. Second the access to publicly provided housing depended upon criteria laid down by local authorities such as 'need' and time of residence in the district. The access to desirable housing was controlled not so much by market forces acting through people voting with their feet or through electoral procedures, but by appointed officials (professionals and managers) in the private financial institutions and the public administration. Spatial residential patterns came to be seen as reflecting the social processes embedded in administration.

The work of Rex and Moore (1967) has been built upon by Pahl (1970) whose writings have close parallels with the 'community power thesis developed in the USA by Lineberry (1977) and Mladenka and Hill (1978). Rather than any external political considerations it is the internal operations of bureaucracies, whether in the state or private sector, that became the centre of attention in the early managerialist writings. Pahl (1970) contended that professionals with specialised knowledge control access to resources. They act as 'social gatekeepers' and through their knowledge they can manipulate their elected representatives to the extent that the political composition of a government, particularly at subnational level, makes little difference to the policies pursued (Leonard 1982, 192). These writers see elected authorities and community pressure groups acting in the pluralist tradition as not possessing the necessary knowledge and expertise to provide effective opposition to managers' policy goals.

As pointed out earlier, such an argument varies little from what public choice theorists claim about the role of managers in bureacracies. The critical difference between them and the managerialist thesis is that privatisation may be actively pursued by managers rather than opposed by them as recognised by Lineberry (1977) and Dunleavy (1986a). According to Lineberry (1977, 171), following Hirschman (1970), dissatisfied consumers need not 'exit' wholesale from a publicly provided service but may choose to opt for provision from a private sector operator. Rather than opposing such an 'exit' public sector managers may even welcome the unloading of potentially troublesome customers. Quoting Hirschman (1970, 60), Lineberry (1977, 171) claims that:

> Those who hold power in the lazy monopoly may actually have an interest in creating some limited opportunities for exit on the part of those whose voice might be uncomfortable.....instead of

> revivifying monopoly [bureaucratic rationalisation in Weberian terms] competition [privatisation] may permit it to remain flabby and complacent.

Invoking the Weberian notion of class, Dunleavy (1986a) argues that by privatising many state services, managers exercise their class power borne of their professional status over a large unskilled or semiskilled working class. Privatisation, according to Dunleavy (1986a, 31):

> advances the (class) interests of central and policy-level officials at the expense of job losses and worsened conditions for rank and file state workers. It also produces a qualitative and quantitative reduction of services to recipients, especially the poor and the working class.

It is largely upon this basis that much of the opposition to privatisation has arisen. In respect of the public interest it may neither increase economic efficiency, as Lineberry (1977) argues, nor be consistent with social justice in terms of maintaining employment conditions and service quality in Dunleavy's thesis. For managerialism, with its founding in organisational theory, privatisation is by no means always indicated as a means to improve efficiency since this is not the prime intention of the policy. Yet the process may well have a degree of bureaucratic rationality since by privatising a concern the administrative procedures within the bureaucracy tend to be simplified and difficult problems displaced onto someone else's shoulders.

Within the managerialist framework then, the impetus for privatisation would stem from within the bureaucracy itself rather than the democratic structure. From a geographical standpoint the spatiality of the process might be expected to reflect variations in the organisational structures and goals of different bureaucracies and their appointed managements. The possiblity of a 'diffusion of innovations' process taking place across regions could be an important factor in the geographical development of privatisation. As the initial success of the policy, whether viewed in terms of efficiency or rationality, is communicated throughout the region, nation state, or indeed across international boundaries, so it could be expected that there would be a spatial unevenness in the implementation of the policy.

To place the diffusion process within any of the two theoretical frameworks considered so far is difficult. Communicating the idea of privatisation across space could be done either by elected politicians responding to political pressures (public choice theory) or by appointed managers trying to rationalise their operations (managerialism). The process of diffusion can therefore be reconciled with either framework. To the extent that diffusion may or may not occur, the more important

theoretical question for both (pluralist) public choice and managerialist frameworks is where the origins of the process lie - with politicians or managers; the democracy or the bureaucracy.

Also of theoretical interest within a managerialist perspective would be the particular nature of services or industries that are privatised and how they compare to those that remain publicly provided. There could be distinct differences in the management structure between services that might well give rise to a sectorally uneven privatisation. The relative degree of professional dominance between services might also be a powerful factor mediating privatisation. So certain services or sectors of industry may be privatised far earlier, and at far greater spatial extent, than others. In this way it may be seen that the geography of privatisation is as much a reflection on spatial variations in what services/industries are privatised as well as where they are privatised.

While presenting a somewhat different theoretical approach to the privatisation debate from that of public choice theory, this exposition of managerialism as an explanatory framework still remains inadequate in many respects. The focus is exclusively on managers at the local (city) state level and there is a distinct neglect of any external constraints on them from either alliances with private sector interests or the central state, although this issue has been addressed in later versions of managerialism as will be seen presently. In as much as a diffusion process may occur, the managerialist (and public choice) framework is silent on addressing the question of what drives the process beyond the whim of individual managers (or politicians).

Whatever the empirical evidence for the autonomy of 'the bureaucracy' from 'the democracy', much criticism has been levelled against early managerialist work through its failure to address the sources of bureaucratic power. According to Saunders (1980, 92), "*it lacked a theory of power and in practice consisted of little more than descriptive data gathering on those who were assumed to occupy important positions*". Paraphasing Basset and Short (1980, 52) writing in respect of the allocation of public housing, "*while managers may implement privatisation policies they certainly do not create the socio-economic conditions under which privatisation is indicated*".

2.3.3 Managerialism and Corporatism

In later writings within the managerialist framework - what may be termed the corporatist approach - there has been a move to identify the constraints, other than purely spatial ones, operating on the policy making decisions of local state managers. In a later work of Pahl (1979),

managers came to be seen as being constrained by a lack of the availability of resources such as land and finance and by limitations imposed upon their decision making capacity by organisations outside of the bureaucracy. Two other key actors come into the decision making processes involved in resource distribution; the private sector (the capitalist economy) and the central state apparatus. The latter might severely constrain the operating budgets of local authorities or the capital borrowing requirements of publicly owned (ie nationalised) industries. In respect of private sector influences on public service provision, Piven and Friedland (1984, 278) cite studies than have pointed to the role of local banks dominating finance boards, developers influencing zoning boards, city centre corportions the urban renewal agencies, and doctors influencing the local health system.

A major concern of writers within the corporatist framework has been the growing size of private sector capitals and the necessity for the state to provide the propitious conditions to attract or maintain their investment in either the national or local economy. Simultaneously the central government has to negotiate with organised labour for any notion of a corporatist alliance between, state, capital and labour to be sustained. Private corporations may seek state financial aid for such necessities as infrastructural development and industrial site preparation while the social costs of private investment like air pollution, public safety and unemployment levels, all have to be underwritten by the state.

In this perspective state fiscal stress arises from the manipulation of state budgets by the actions of private capital. But just as importantly for Pahl (1979), writing before the advent of the current Conservative administration in Britain, is that, "*the state is playing an increasing role in allocating resources. Housing, education, health the social services and so on consume enormous* [public] *resources*" (Pahl 1979, 38). At the same time however the state has assumed a greater financially supporting role in relation to the private sector with the establishment of 'enterprise zones' and 'development corporations' being major examples.

The intense interaction between the state and private capital has led to the conception of a corporatist society in which a form of economy intermediate between capitalism and socialism is hypothesised; that of private ownership of the means of production (capitalism) but state contol over the operations of the economy (socialism). While not referring to corporatism as such, Gurr and King (1985) detail the increasing role of the state at both local and national level in affecting the economic and

demographic viability of cities. Within this corporatist framework, the state can then be seen as operating in the public interest insofar as this requires a modification of the activity of the operations of market forces. The centralised state is viewed as imparting efficiency criteria in its administration of both the public and private economy.

The important point about this corporatist perspective of state sector activity is that managers, as decision makers, are no longer seen as omnipotent but simply as mediators between the contradictory pressures. On the one hand there are the often opposing forces of central government regulation and the need for service provision while on the other hand there is the need for maintaining private sector profitablity while still fulfilling social needs. In short the managers are neither autonomous nor irrelevant but constrained by a combination of geographical, economic and political factors (Saunders 1981, 195). The original Weberian framework of the early managerialist writing is still maintained insofar as the key actors in resource allocation are individuals rather than social classes and the role of appointed officials still prevails over that of elected representatives.

In respect of implementing privatisation policies, the locus of power would still be sought in the role of state sector managers but consideration also has to be given to the structural constraints under which they operate. Trapped between the lack of available government finance and their requirement to maintain services, privatisation may be readily resorted to where it is thought to be a cheaper, if not necessarily more efficient, alternative to public provision. Geographical variations in the development of the process must then be located in spatial differences between the interaction of the state, private capital, the workforce and the community. While this undoubtedly presents a more sophisticated account of resource allocation than the earlier managerialist writings, it still leaves certain issues unresolved.

There is in particular a failure to explain theoretically the social origins of the constraints identified on the policies of state sector managers. No account is taken of changes in macro-economic forces, stemming from the capital/labour conflict, that have provided or restricted the role of state sector institutions. Neither have regional variations in the level of local 'on-site' class conflict been considered as possible mediating factors in the uneven development of the privatisation of public service provision. These criticisms have led researchers into the field of Marxian theory in an attempt to provide a broader understanding of the dynamics of state sector activity. From an essentially institutional or

state centred explanation of privatisation, the debate moves to one centred on class conflict.

Summary and Conclusion:

The above discussion has shown that neither the public choice nor the Weberian frameworks provides a comprehensive explanation of social processes such as privatisation although each may have a certain contribution to make. The essence of the public choice explanation for privatisation is that public sector bureaucracies grow inexorably because of ill defined or non-existent property rights. This enables managers to pursue a maximisation strategy to the detriment of both the productive private sector and, by extension, the public interest. In order to revitalise economic growth it is necessary to reduce the role of the state by privatisation, and reorganise the residual elements of the state apparatus so that they replicate the operations of the market economy.

The Weberian approach to the state sector sees its existence as being a rational, and possibly even efficient, complement to the market economy. Privatisation is not so much seen in terms of increasing economic efficiency but as being a rational means of dealing with complex organisational problems. Notwithstanding the enormous political power that managers have through their access to information, they do nonetheless have the potential, even if not always realised, to pursue the public interest by implementing policies aimed at social equity rather than just market efficiency. In this view privatisation is by no means always in the public interest whether the latter is understood in terms of social equity or economic efficiency.

Both theoretical frameworks however tend to ignore the broader socio-economic forces at work which may severely constrain the activities of the state sector. The question that remains is what is the social driving force lying behind the actions of state sector managers or elected representatives of the community. There is also a need to explain how any external forces acting on bureaucracies enable privatisation policies to develop in a geographically uneven context. It is towards addressing these issues from within a Marxian framework that the next chapter is devoted.

Footnote:

1 An example of the difference between bureaucratic rationality and economic efficiency arises in the case of promoting workforce personnel. Where seniority applies, as is usually the case in the state sector, the process is rational insofar as it is simple, unambiguous, non-discriminatory and prevents patronage, nepotism, and corruption. It might however be to the detriment of an institution's efficiency as a totally unsuitable person may be promoted. Where suitablity rather than seniority applies, as in the private sector, greater efficiency may be realised but

the procedure could be less rational where opportunity opens up for all the above mentioned shortcomings.

CHAPTER 3

Theoretical Perspectives on the Development of Privatisation 2: Marxian Theory

In contrast to Weberian and public choice perspectives, Marxian theory sees the roles of managers and elected government representatives in policy making decisions as being subordinate to the overriding requirements of capital accumulation and the class conflicts engendered in the accumulation process. Explanations for policy outcomes in respect of social processes like privatisation are sought in terms of the balance of class forces in existence at any one time and place. This chapter addresses itself to analysing the role of class conflict in mediating the development of privatisation policies and examines some of the recent and continuing research in this field in the context of locality and regional studies.

The chapter commences with a brief account of the rationale for state involvement in the market economy as a means of securing capitalist production. The contradictions inherent in capitalist production and the attempts by the state to resolve them lead to an assessment of the frequently cited *Fiscal Crisis of the State* by O'Connor (1973). Being perhaps the first specifically Marxist account of state expenditure under advanced capitalism, it has been extensively reviewed over the years since its first publication. A further look at the work however is justified in order to examine its potential to explain the development of privatisation policies. The theoretical shortcomings of the work in explaining state activity in general, and privatisation in particular, are detailed and this leads to a third section which presents a Marxian account with a far greater emphasis on class conflict, rather than simply the requirements of capital.

The issue of geographical variations in the levels of class struggle is given prominance in this section in order to determine their affect on the uneven development of privatisation. The likelihood of class reductionism in this approach, together with the functionalism of O'Connor (1973), has largely been responsible for a thorough ressessment of the relevance of Marxian theory for explaining social phenomena. Recent contributions in *Antipode* and *Society and Space* (1987) are testimony to the extent of this reassessment, and the significance of these writings to the privatisation debate is discussed in the final parts of the chapter. Attention is given to the attempts being made to move beyond the limitations of the Marxist framework by placing a far greater emphasis on empirical work set within local and regional contexts. The relevance of

this work for explaining privatisation at different spatial scales is assessed and a case established for doing further theoretically informed empirical research on the geography of privatisation.

3.1 The Provision of Public Infrastructure for Private Production:

From the earliest days of capitalism, the state has been involved in the provision of major infrastructure in the field of communications (eg posts and telegraph), transport (eg roads and canals) and national defence. Even the classical economists presented in chapter one saw a positive role for the state to play in this arena. State intervention in the market economy first arose in order to secure what Marx (1973) in *Grundrisse* called the general conditions of production. These served to speed up the circulation of commodities and comprised many of the items necessary for commodity production that are either used collectively by capitalists or else are not directly included in the production process itself. The rationale for the state to embark on providing the general conditions of production has rested primarily on the inability of private capital to do so.

Drawing on the account of Dunford (1988, 54), for private capital to supply these major means of production there must be:

1 Very large amounts of money capital available as the investments required are usually large and costly.

2 Investors prepared to commit money to projects where capital turnover is very slow and there is a high element of financial risk.

3 Ample opportunity to sell the products of production at prices which give an adequate rate of return on investment.

For this third condition to hold, property rights must be clearly established so that goods and services are exchanged at value and so-called 'free riders' excluded. Dunford (1988, 55) concludes that where investment in the general conditions of production are not capable of yielding an average rate of return on capital invested, then adequate provision is likely to depend upon state action. On this basis it would be worthwhile to reflect upon how much public infrastructure would ever have been built had, say, a 10 percent real rate of return on investment been required.

The process of state intervention to enable the private production of commodities has not however been a contradiction-free process as was seen in the first chapter's discussion of Offe (1984). The specific ways in which the state attempts simultaneously both to maintain and negate the commodity form of production have been identified in the work of O'Connor (1973). The basic argument presented is that the state has to bolster capital accumulation (the commodity form) while at the same time

establishing social legitimacy which requires decommodifying production. The end result is a 'fiscal crisis' of the state.

It is worth emphasising that many other works have analysed the theoretical underpinnings of state fiscal crisis. Some have been essentially Marxist (eg Piven and Friedland 1984), others decidely non-Marxist (eg Wildavsky 1985), while at a more empirical level the public policy implications of fiscal crisis are thoroughly examined in the contributions to Hubbell (1979) and Levine and Rubin (1980). In this account, however, it is specifically the work of O'Connor that is examined in view of the originality of his theoretical approach to Marxian inquiry and its relevance in explaining the current growth of privatisation. Although presenting a rather underconsumptionist account of capitalist production and a functionalist explanation of state expenditure (see Schwartz 1983), O'Connor's work has nonetheless provided a benchmark for Marxian analyses of changing public sector economies.

3.2 State Fiscal Crisis and Privatisation: The Contribution of O'Connor:

According to O'Connor (1973) the growth of monopoly capitalism in the 20th century has required the state to underwrite many of the costs of private production for the reasons outlined above by Dunford (1988). To this end there has been a dual function for the state. On the one hand has been the requirement to provide social capital. This amounts to supplying the necessary conditions for capital accumulation such as major infrastructure, and an educated, healthy workforce. On the other hand this accumulation has had to be legitimated to the population by the provision of extensive welfare services - social expenses - none of which however makes any contribution to accumulation. Included in the category of social capital is social investment and social consumption. The former amounts to expenditure on capital works such as roads and railways and the latter is expenditure on labour power in the form of education, health, and urban passenger transport. The state intervenes to take up the burden of what would otherwise be costs to private capital.

At the same time however capitalists privately appropriate the returns on publicly subsidized investment, and consequently state bureaucracies no longer have adequate funds to perform their legitimation function (Fainstein and Fainstein 1980). For example, capitalists reap the benefit, in the form of private profit, of employing a predominantly publicly (ie tax payer) educated and trained workforce. The state has therefore socialised many of the costs of private production but not socialised the profits. There arises therefore a large gulf between state revenues (from taxes on wages and profits) and expenditure on non-productive welfare. In

this context the privatisation of much state sector activity could be seen as addressing this expenditure gap.

An alternative to privatisation might suggest itself in the form of increasing the taxation on capitalists' profits. The main difficulty with this is that it simply reduces the level of profit and encourages private industry to relocate to more favourable financial regimes, in which case the state's tax base is eroded. This means that fewer resources (surplus value) are available for further investment. Taxation on workers' wages amounts to an indirect reduction of surplus value as, were it not for the taxes, workers could be paid that amount less by capitalists without any reduction in real wages or living standards. There would then be more surplus value to reinvest in further rounds of production.

Taxation reduces both workers wages and capitalist profits, thereby giving scope for intense political pressure to reduce the role of the state in order that the tax burden may be reduced. As was seen in the previous chapter, there have been outright tax revolts particularly by property owners in the USA, which in certain cases have seen a substantial reduction in state supplied goods and services in some cities. The term 'minimal city' has been applied by Millar (1981) to the situation in which, to minimise property taxes, the city authorities have contracted out most of their major services to county governments rather than establish municipal bureaucracies.

O'Connor focused his study on the USA, where so much public expenditure is by the local state at the city level and is financed out of local property taxes. In more centrally governed countries, like the UK, the fiscal situation at the city level has been rather less severe although still troublesome. Here most public expenditure is centrally financed while services are still administered through local bodies. Elliot and McCrone (1984) prefer the term financial strain rather that fiscal crises for the UK situation and they cite inflation as being a major stress factor rather than a dwindling tax base. Nevertheless an important underlying feature to the cutbacks to public service provision was that the UK economy was neither sufficiently productive, nor internationally competitive, to fund both its welfare provision and the heavy military spending first embarked on in the fifties and sixties (Gamble 1987, 191). Faced with local rate-payer revolts and reductions in the level of central government financing, public services have come under increasing threat from the seventies onwards.

Rather than being able to finance the provision of existing services, through further taxation on capital, governments in many countries, both

local and national, have often had to reduce, or eliminate, the taxation on company profits. Only in this way could private investment be attracted. So called 'enterprise zones' are an important example. As most of the working class do not have sufficient incomes to enable the imposition of significantly higher tax levels, the main burden of taxation in late 20th century capitalism has increasingly fallen on the professional salariat, or what Wright (1976) has termed the new petite bourgeoisie[1].

It was pointed out in the first chapter, that this class, with its high salary, has least need of state provided and tax payer subsidised services. Arising largely from this quarter, much anti-state sentiment has arisen with calls for implementing a less progressive tax structure in which there is less redistribution of wealth from the poor to the well off. This has occurred under the 'monetarist'[2] policies of some governments during the 1980s. The important theoretical point from a Marxian perspective is that the underlying basis for this regressive policy lies in the requirement of capitalism itself rather than in political campaigning against perceived government inefficiencies. As Piven and Friedland (1984, 399) point out:

> Consequently the tax revolts of homeowners represent a popular response to the inability of the public sector to finance the public expenditures required by advanced capitalism without also cutting deeply into popular incomes.

The capitalist class, for obvious reasons, also opposes the imposition of heavy tax burdens. Unlike the professional salariat however their taxes can often be minimised. A major example of this is the 'transfer pricing' policies of multinational companies in which their profits are only declared in countries with the lowest tax rates. For the capitalist class it has been the comprehensive state welfare provision that has been particularly contentious since it increases the bargaining power of labour (Piven and Cloward 1982). With the welfare state, workers become less compliant with workplace discipline and there is a decreased dependence of the propertyless upon the labour market for their subsistence (Therborn and Roebuck 1986).

The analysis can be extended beyond just state welfare institutions towards explaining the privatisation of the state's industrial sector. Frequently state owned industries have provided what amounts to a *de facto* welfare or legitimation function. Typically this has occurred through providing employment to people displaced from the private sector where the competitive drive for profit has resulted in labour-displacing technological innovation. This has often resulted in a state sector economy which is seemingly chronically overstaffed and hence inefficient.

In the words of Schwartz (1983), paraphrasing O'Connor (1973):

> monopoly[a] sector growth, for the most part owing to increased capitalization..... involves a concomitant decrease in the monopoly [ie private] sector labour force. Workers displaced by this process are either hired by more labour-intensive competitive sector industries at lower paying positions, become state sector employees, or find themselves dependent on the state's welfare provisions (Schwartz 1983, 45).

The public sector therefore socialises the costs of the private sector's labour shedding drive for profit by creating, if possible, employment opportunities and, if not possible, by providing welfare (unemployment) benefits. Following the conservative motto, 'more business in government and less government in business', policies have been implemented in the 1980s to privatise various state sector industries by separating commercial from social objectives and establishing them as self-financing businesses, just as a private concern would be. A prime example of this was the establishment in New Zealand in 1987 of state owned enterprises (SOEs) which were required to yield a profit. The restructuring and privatising of the state industrial sector generally entails substantial labour shedding as happened in the formation of New Zealand's SOEs. A consequence of this is that workers' bargaining power tends to be weakened. This may lead to depressed employment conditions and a consequent transfer of wealth from labour to capital.

The inability of the capitalist state to resolve the contradiction between capital accumulation and social legitimation has lain at the heart of what many writers have referred to as a collapse of 'consensus politics'. Under this arrangement all main stream political parties maintained a commitment, to varying degrees, to uphold a public sector economy. But through governments underwriting the social costs of private profitability there has been a crisis in (private) production itself. This in turn has threatened the existence of the public sector economy and reduced the pre-existing political commitment to maintain it. Upon this basis a polarisation of political views has developed, largely between those on the Right who would roll back the frontiers of the state to restore private profitability, and those on the Left committed to the maintenance, if not expansion, of public services and the public economy as a whole. In this way privatisation becomes a highly political policy and seen as one in which capital attempts to reassert its domination over labour.

The main theoretical conclusion from O'Connor's thesis is that the political pressures for privatisation arise directly from the state underscoring the drive for private capital accumulation. This approach

arguably sets the privatisation debate into a broader social framework than the public choice and Weberian ones considered previously, but it still cannot be accepted without criticism. Even though state expenditure is seen to have a contradictory effect, it occurs entirely at the behest of the internal workings of capitalism itself and presents a functionalist analysis. There is moreover the important empirical observation that states under similar fiscal constraints/crisis may pursue very different policies on privatisation. O'Connor (1973, ch5) details, and quite extensively, the geographically variable effect of state fiscal crisis between city and suburb. The major shortcoming, however, is that his thesis does not address itself to explaining variations in socio-economic conditions between both different suburbs and different cities.

In many respects this mode of analysis is not a great deal different from a public choice framework as pointed out by Peters (1980) and Gans (1984) even if the political conclusions drawn are very different. For public choice theorists state fiscal stress is primarily an issue of demand for services outstripping the supply of resources, whereas in the Marxian perspective accumulation of capital is no longer sufficient to fund the necessary social legitimation measures. While the former sees the reinforcement of capitalism, through privatisation, as the resolution of the problem, the latter sees capitalism itself as the problem.

Perhaps however the main difficulty with O'Connor's thesis is that it only considers state actions in respect of the needs of capital. But while capital has 'needs', labour has 'demands' and the state has had to act in the context of these struggles (Burden and Campbell 1985, 17). Although O'Connor (1973) states that, "*if those who are dependent on the state do not engage in political struggle to advance or protect their wellbeing, the fiscal crisis will remain relatively dormant*" (O'Connor 1973, 206 cited in Schwartz 1983, 47), it is crucial to show explicitly, which O'Connor fails to, "*how the actions of the relevant actors and institutions temper the dynamics of the fiscal crisis*" (Schwartz 1983, 47). The following section shows how Marxist accounts subsequent to O'Connor have attempted to move into the realm of class conflict. By referring to certain empirical studies it is intended in this section to show how heightened class conflict can inhibit the implementation of government policies such as privatisation.

3.3 Class Conflict, the State Sector and Privatisation:

In order to transcend the functionalism inherent in O'Connor's underconsumptionist account of state expenditure there has been an attempt to invoke the role of social class conflict. Rather than being functional

(or dysfunctional) for capitalism the growth of public expenditure is, in part at least, the result of class conflict through struggles to secure the social wage. Within a geographical context it might then be expected that privatisation policies would be mediated across both space and time by different levels of class conflict that prevail. This is not to dismiss the importance of spatial variations in political systems in the formation of public policy. Instead it is to argue that, in the Marxian context, the underlying basis for any political power largely arises out of class struggles.

In the writings of Gough (1975, 1979) it is maintained that much of the difference in public sector activity between nations can be attributed to the relative strengths of their respective labour movements. Consequently the lower level of public welfare and state owned industry in the USA compared with most of Western Europe is due to the absence of a unified labour force with political representation via a parliamentary social democratic, if not socialist, party. According to Gough (1975, 65) mass based class action can threaten the security of the capitalist class to the extent that the latter will pressurise the state apparatus to defuse the conflict by introducing ameliorating interventionist policies - 'social welfare as the antidote to social(ist) revolution'. All governments, Gough argues, "*whatever their political complexion depend for their survival under bourgeois democracy on their ability to offer <u>certain</u> reforms and concessions to the struggles of the dominated classes*" (Gough 1975, 66 emphasis in original). In this way state intervention need not be explained simply in terms of pre-existing requirements of capital.

The advantage of this approach is that any crises of capitalist production can be viewed in terms of the inability of capitalists to maintain their dominance over labour instead of this just arising from the internal workings of capitalism itself. Further attempts to incorporate class struggle, and therefore human agency, into the debate, have led some writers following a Marxian framework (eg Susman 1981, Ross 1983, Trachte and Ross 1985) to locate the changing role of the contemporary capitalist state into the dynamics of global capitalism. Susman (1981, 15) claims that the current period of advanced capitalism is qualitatively different from earlier periods in three important respects. First is the far greater than hitherto concentration and centralisation of capital, making entry into various industries almost impossible for small enterprises. The second is the lack of state controls over the investment and disinvestment policies of multinational companies, while third is the expansion of corporate manufacturing production in socialist and Third World countries

(Susman 1981, 15).

These developments in capitalist production have had far reaching effects upon the workforces involved. To attract investment from increasingly internationally mobile capital, state policies have to ensure appropriate conditions for profitable investment. Goodman (1979), referring to the state as *The Last Entrepreneur*, provides a vivid account of this and a wealth of supportive examples. For the working class and many public officials, the era of global capitalism pits them against a Leviathan. According to Ross (1983, 249), "*each local advance or reform may be subverted by the investors ability to evade it by moving away*". But the process is not by any means an automatic one and is rather the outcome of a balance of class forces and state policies. While recognising that, "*the state may be dominated by the interests of capital, or at least constrained by the structure of capitalist relations as a whole*", Ross (1983, 251) argues that there are spatial variations which exist in the success workers achieve in obtaining policies in their interest.

In the case of Italy, Dunford (1988, 24) details how between 1966 and 1974 a series of frequent and forceful revolts against the conditions of work in modern industrial plants occurred, often under the leadership of unskilled, immigrant, young and women workers. Using graphs to illustrate how indices of strike action (in hours lost per employee per year) and union membership (as percentage of active population) increased substantially between the mid sixties and seventies, (Dunford 1988, 131) shows how, "*employers were largely prevented by union strength from raising productivity and restoring profitability by reorganising work or laying off workers*" (Dunford 1988, 135). The immediate implication is that working class militancy can readily thwart the viability of capitalist production.

The historical course of class confict is not however a unidirectional one and capitalists continually search for ways to circumvent the advances gained by workers. Geographical mobility in production has been one such way frequently resorted to over the last two decades. From a study of industrial relocation in the USA, Peet (1983) has developed an index of class struggle based on factors such as levels of unionisation, wage rates, work stoppages and 'business climate'. He uses this to show how industrial relocation from the North East to the southern States reflects the lower levels of class struggle in the latter.

With specific reference to the privatisation of state sector activity, the industries concerned are more spatially fixed in terms of international mobility than those considered by Peet (1983) and Dunford (1988);

railways, telecommunications, schools and hospitals are typical examples. In these cases privatisation, as a response to working class strength, may involve the spatial fragmentation of industries or institutions on a regional basis. For example in the 1970s and 1980s freight distribution has been substantially transferred from rail (public) to road (private) transport while more recently health care facilities have started to be transferred from large public institutions to smaller (private or voluntary) ones. In each case working class organisation becomes much more difficult.

A specific case study of working class resistance to privatisation is provided by Elliot and McCrone (1984). They detail the opposition mounted in two districts of Scotland to central Government's requirement for local authorities to sell (ie privatise) their stock of council (ie public) housing. In one of them:

> Between February and September 1981, there were strikes and rallies, petitions were signed and MPs lobbied. Many hundreds of trade unionists, local authority workers, council tenants and others participated in what the Lothian Region Joint Trade Union Committee dubbed, 'the battle for Lothian' (Elliot and McCrone 1984, 204).

In the other district, public housing existed on a very large scale and was very much part of the social wage for the working class. Resistance to the privatisation was led by the largest trade union in the district and, Elliot and McCrone (1984, 206) report that, throughout the 'no sales' campaign in 1980-81, "[the Union] *did more than any other agency to mobilize support and shape oppositional strategies*". It was able to link workplace and community struggles over the maintenance of the social wage. The important theoretical point made clear by this example is that unified class action can do much to thwart the implementation of privatisation polices. The geographical development of privatisation therefore may be expected to be strongly mediated by regional variations in levels of class conflict.

In some respects Elliot and McCrone's analysis is more in the Weberian than the Marxian tradition with its focus on the actions of trade union and local council bureaucracies rather than strike action at the point of production. Nevertheless they do indicate the effectiveness of working class mobilization to counter privatisation. It may be argued that much more empirical research could still be done to detail how geographical variations in levels of class conflict have mediated the development of privatisation policies and other forms of state sector reorganisation. Such an approach may overcome some of the objections of the earlier

attempts at Marxist analysis but there still remains room for dissatisfaction with it as being a comprehensive explanatory framework. Insofar as class struggle is cited as the critical variable there is a tendency to class reductionism by ignoring the possibility of non-class factors having an important or even decisive role. A theory more sensitive to the diversity of human action is required.

3.4 Beyond the Marxist debate; Towards a Reassesment of Theory:

Possibly the main limitation of such Marxian inspired analyses using class conflict as the major explanatory variable for actions by the state is that, as Pinch (1985, 157) notes, "*broad categories of labour and capital are inadequate to explain the large diversity of interests and pressure groups involved*". The usual stance of Marxist writers has been that, sectional or urban struggles in the world of consumption are seen as outgrowths of class struggles in the world of production (Castells 1975 and Harvey 1978). As the above study of Elliot and McCrone (1984) has shown, state supplied consumption goods and services are part of the social wage paid by capital to labour and struggles over their retention are just as much class struggles as those over employment conditions and job retention in the world of production.

For many writers however the emphasis on the role of class forces is too simplistic as the actions of decision makers in state institutions and of community group resistance may not all be reducible to class conflict. For Gans (1984, 284) writing specifically about the USA:

> Struggles that have nothing to do with the economy over issues of race, religion, ethnicity, power and culture take place in American communities in which class, in the Marxist, Weberian or Warnerian sense is sometimes only a side issue.

Laws (1988) has also observed that pressures to privatise are not just top down state induced policies but come from a wide cross section of the community, including service users and providers themselves. In some recent writings on the welfare state (eg Barnett and Barnett 1989) there has been a move to attribute the cut backs it is enduring largely to overtly political factors rather than the requirements for capital accumulation or the balance of class forces.

3.4.1 Back to Managerialism and Public Choice Theory?

Mohan (1988), following a critique of Gough (1979) by Hindess (1987), maintains that:

> It is functionalist to argue that because welfare cuts may be against the short or long term interests of capital, '*we would expect to find not so much cuts or dismantling of the welfare state as its restructuring*' [Gough 1979, 138] without specifying the precise links between the interests of capital, government

political strategy, and restructuring (Mohan 1988, 451)

While these points are well made, it can be countered that it is equally important not to present explanations of privatisation and other state sector activities as lying entirely within the realm of politics. Thus the above passage taken from his discussion of the privatisation of health care in England, is followed immediately by the claim that Conservative party policy is the primary explanatory variable through its:

> critique of bureaucracy and a belief in the inefficiency of the public sector, an attack on trade union power, and an emphasis on value for money and the need for determined management (Mohan 1988, 451).

This however takes the debate almost back to the Weberian perspective in which the focus of attention is on a descriptive analysis of the activities of the state bureaucracy itself in implementing policies. Virtually no discussion is presented of how changes in the structures of UK and international capitalism have provided the context for Conservative political policies towards privatisation. Perhaps even more importantly in view of the examples cited in the above section, little or no account is given of work force resistance involved in the opposition to such policies. This is in no way to deny the importance of the political sphere or to elevate the process of capital accumulation and class conflict to a determining role. Instead it may be argued that the implementation of government policies needs to be set within an analysis of changes in the socio-economic forces of which capitalist state are integrally linked to. It should not be forgotten that significant amounts of state sector 'rationalisation', if not strictly privatisation, of the UK economy occurred prior to 1979 under a Labour administration.

A similar critique of Marxist inspired accounts of state sector cutbacks and privatisation has come from Dunleavy (1986b) who, like Mohan (1988) argues that:

> they do not provide any detailed account of the causal mechanisms by which changes in the economic or ideological priorities of corporations and capital owners can translate effectively into alterations in state policy (Dunleavy 1986b, 130).

The question of interest to Dunleavy is:

> How is it that the electorates, political parties, political leaders, policy advisors and the mass media in advanced industrial states recognise and respond to the changing priorities of capital? (Dunleavy 1986b, 131).

By way of explanation he develops the thesis that the growth of the welfare state in a capitalist society is a politically self-stabilizing process. This is explained on the basis that:

> As the historic rationale for [state] intervention recedes to the status of a folk memory, and the deficiencies or inconsistencies

> of current policy replace them at the forefront of attention, so we might expect public support for continued intervention to decay (Dunleavy 1986b, 135).

Be this as it may, the question begged is if the welfare state is politically self stabilising, at what level will it stabilize and why? Is there indeed an equilibrium point for welfare state provision? A similar theme is expressed by Therborn and Roebuck (1986, 332) who have argued that, notwithstanding much recent privatisation and cutting back of services, the welfare state is:

> irreversible by democratic means [because] the size of the population benefitting from the welfare state ensures that as long as democracy accompanies advanced capitalism, the core of the welfare state is safe.

There is a certain degree of empirical support for this contention from the pronouncements of some political leaders that certain parts of the welfare state are 'safe in our hands'. While it may be argued that there is a certain irreducible minimum for the welfare state in advanced capitalism, the important theoretical question is to ascertain what social forces will determine the 'minimum' or the 'equilibrium'. The welfare state, just like the capitalist production process itself from which it has assumed its *raison d'etre*, is in no way politically or economically self stabilizing unless one disregards the destabilizing and contradictory effects that class conflict under capitalism engenders. Accounts such as Dunleavy (1986b) and Therborn and Roebuck (1986) tend to ignore the variety of oppositional strength that has, albeit spatially unevenly, been generated against state sector cut backs and privatisation. Although trying to distance himself from the conclusion, Dunleavy (1986b, 135) comes close to admitting the similarity between the process of self stabilization he is presenting as an explanatory factor and a pluralist public choice 'issue attention cycle' first proposed by Downs (1972).

It can be seen then that the debate on explaining privatisation has come full circle back to the original public choice framework. Largely on account of this there has recently opened up a schism in radical geography on the relevance of Marxian class conflict to explain social reality. The necessity to consider the explanatory potential of political factors which cannot all be simply reduced to the demands of labour or needs of capital has required some recent rethinking of the relevance of Marxian theory as an analytical tool. In view of the enormous geographical variations in capitalist societies that have occurred across time and space in social processses like welfare state cut backs and industrial restructuring, Marxian methodology is thought by some to be too much of a 'totalising

discourse'. It is insufficiently sensitive to the details of human existence. As Duncan (1989, 128) remarks:

> understanding how capitalist society works at a general level seemed to have little connection with how people acted; ignoring the abstract expose they voted in large numbers for right wing governments both in Europe and North America, governments which then set about reinforcing the very injustices which research had indicated and explained.

Although this is hardly a new observation, what is new is the concerted attempt to try and bridge the gulf between social structure and human agency. By undertaking, detailed theoretically-informed, empirical studies in localised geographical contexts, the intention has been to gain greater understanding of the way in which people create their own lives or histories. With reference to privatisation the question is to determine why the policy may have become so much more entrenched in some regions rather than others even where similar overall socio-economic conditions prevail.

3.4.2 Locality Studies and Regionally Uneven Development: A Return to Empiricism or an Advancement of Theory?

The regionally uneven development of capitalism has been of much concern to Marxist geographers. The existence of unevenness in development, whether of industry, public services or general human well being, has been recognised since the days of Marx himself and over 100 years later the issue is still far from resolved. A question of much theoretical significance is why the unevenness not only persists but has become even more accentuated at all geographical scales?

To this end, public choice theories are not particularly illuminating since, according to Tieboutian logic, regional inequalities would be expected to even out with the operation of market forces. Regional disparities in development are not problematic in this scenario (unless they threaten systemic stability) as their existence is seen as merely an unwillingness of people to move in response to the alleged self equilibrium of market forces. The theoretical importance of regional disparities from a Marxian viewpoint is that the unevenness provides a distinct social and spatial fragmentation in the class opposition to capitalism. Not surprisingly then class forces, not market forces, come to be the subject of analysis. But as just seen, regional uneven development cannot readily be explained in terms of class forces alone.

Many Marxist-inspired geographers have recently come to devote more attention to changes in social phenomena such as labour markets, divisions of labour and public service provision within a specific regional setting. Efforts have been made towards trying to explain why such geographical

variations occur in these processes within the totality of capitalist social relations. Stimulated largely by the seminal work of Massey (1984) a plethora of 'locality' and 'regional' studies have emerged since the mid 1980s. A major example is the CURS[4] initiative (Cooke 1986) which has investigated the causes of deindustrialisation in the UK and focused its empirical research on seven urban settlements as being representative of localities.

Much research within the 'locality studies' arena has been grounded in the theory of structuration due to Giddens (1984), which specifically attempts to bridge the ever-problematic theoretical gulf between individual actions and social structure in both time and space. Structuration theory has sought an understanding of social reality through emphasising both the opportunity and constraints for human activity. In this vein the emphasis in locality studies is placed on the intentional nature of human action in the development of regions and communities.

The interaction of many factors not easily reducible to the effects of capitalist social relations provides each locality studied with a distinct uniqueness. Broader non-local structures, whether of the central state or global capitalism, are seen strictly in a limiting rather than a determining role. Methodologically the approach is very much 'bottom up' rather than 'top down' and general theories of capitalist development which are not place specific have been eschewed. But to accord with structuration theory, localities are not analysed as if they were solely the products of conscious human decisions. Rather they also reflect the unintended consequences of human activity and these consequences then become constraints, or structures, upon further conscious actions.

An example of the way in which structuration theory may be applied would be to consider a workplace strike for achieving advanced working conditions. This may have the unintended effect of seeing the workplace close down altogether and move out of the region. So rather than improving working conditions, there may be no work at all. This ability of capital to be geographically mobile then becomes a constraining factor on further conscious decision to secure working conditions. The social structures which exist within capitalism, as expressed at the local level, are therefore both enabling and constraining. In the 'new geography' there is a recognition of the 'boundedness' of human activity within capitalist society but hitherto it seems the debate over the precise theoretical status of locality research in relation to capitalist development and Marxian political economy is far from resolved.

The issue has received a thorough airing in *Society and Space* (1987) and recent editions of *Antipode*. Cochrane (1987) has succintly summarised the respective positions in the localities debate. For committed managerialists, their position is exemplified in the tirade against Marxism by Saunders and Williams (1986) in which, according to Cochrane (1987, 355), the claim is that the 'new geography' is little more than a "*cover for structural Marxism with a human face*". On the other hand for those such as Harvey (1987) and Smith (1987) who maintain that Marxism has overriding explanatory significance, recent moves in an empirical direction are but covers for, "*a return to empiricism with a theoretically sophisticated face*" (Cochrane 1987, 355).

Warf (1988, 182) has possibly cleared the air somewhat by arguing that, at the dissagregated level of the locality, the ability of humans to exert a considerable, even if limited, influence over their environment is manifest. At successively larger spatial scales however the explanatory utility of theories centred around conscious action declines. Warf (1988, 183) supports this contention by asking, "*does structuration theory reveal much about the deindustrialisation of the Rustbelt, the behaviour of multinational firms, or famine in Africa?*". To this list may be added, the privatisation of the state?

Summary and Conclusion:

This chapter has outlined the two major variants to the Marxian perspective on state expenditure under advanced capitalism. These may be termed the underconsumptionist version due to O'Connor (1973) and the class conflict version of Gough (1975). The characteristic features of each in regard to explaining the development of privatisation initiatives are presented in tabulated form in figure 3.1, where they are compared with those of the public choice and Weberian perspectives. As this, and the previous chapter has shown, none is without serious theoretical shortcomings, and yet each may have a certain degree of empirical validity. In the final part of the chapter a summary was given of some recent empirical work conducted at a local and regional scale. The research has been aimed towards gaining a greater theoretical understanding of social reality than is provided by the three frameworks previously detailed. To the degree that there is still a distinct dearth of understanding of the uneven development of social processes, a greater need for empirical research is indicated in order to advance the theoretical explanations on offer.

By taking an empirical example of spatially uneven privatisation as a specific case study, it is intended in this thesis to examine critically

FIGURE 3.1: Theoretical Frameworks for Explaining the Privatisation of the State

Public Choice (Democratic)	Weberian (Bureaucratic)	Marxian (Class Relations)
Pluralist	Managerialist	Underconsumptionist
Consummer preference for private provision 'voiced' through democratic procedures	Privatisation from autonomous state officials following 'bureaucratic rationalisation' plans	Privatisation since insufficient surplus value production for private profit
Public Economy	Corporatist	Class Conflict
Consummer preference expressed through 'exiting' to private sector	State officials under conflicting pressures and privatistion is outcome of the relative strength between them	The implementation of privatisation contingent upon balance of class forces

each of the three theoretical perspectives. The aim in the subsequent chapters is to ascertain the extent to which each theory may provide at least a partial explanatory base for the uneven development of the process. Explanations of the localised development of privatisation are sought but with emphasis on the pivotal relationship with broader socio-economic forces. Rather than rejecting any one theory *a priori* and recognising that monocausality of social phenomena is seldom valid, it may be possible through empirical research to establish a 'hierarchy' of explanations of geographically uneven privatisation. With this end in mind it is suggested that the explanatory power of different social forces (elected representatives of the community, private capital, the central state, the labour movement, or the changing role of the economy under global capitalism) may have varying relevance at certain times and places.

Before proceeding in this direction attention in the next chaper turns to examining some of the different processes through which privatisation may occur. Thus far in the discussion privatisation has been analysed as a unitary process. It will be seen how different forms of privatisation may be applied to particular areas of state activity.

Footnotes:

1 Wright (1976) distinguishes the new, from the old or traditional, petite bourgeoisie on the grounds that the latter comprise shopkeepers, artisans, trades people and those who are generally self employed. They neither employ (exploit) wage labour nor do they produce surplus value for capitalists. According to Wright the numbers of the traditional petite bourgeoisie have dwindled in the 20th century while the new class of professionals and managers - the new petite bourgeoisie - has increased substantially.

2 Monetarism is the term that has come to be applied to much Right wing economic theory. Basically it maintains that inflation is the root cause of all economic difficulties and can only be controlled by limiting the money supply. The way this is achieved is by reducing public (state) expenditure to a minimum in favour of free market forces. The main contemporary advocate of this policy has been Milton Friedman of the Chicago School of economics.

3 O'Connor identifies two subgroups within the private sector: competitive industries organised by small business and monopolistic industries organised by large scale capital (O'Connor 1973, 13). It is the latter, rather than the former type of industry that has imposed the heaviest demands on state expenditure.

4 CURS: Changing Urban and Regional Systems

CHAPTER 4

The Processes of Privatisation

One of the major difficulties in giving conceptual clarity to the term privatisation has been the number of different forms or processes through which the policy may be implemented. The identification of the possible forms that privatisation policies may take is addressed in this chapter and illustrative empirical examples are provided from different parts of the world, but particularly Britain and New Zealand. In this way a framework is established for providing a detailed case study of the geographically uneven development of one particular form of privatisation.

The chapter opens with a section devoted to the forms of privatisation identified in some of the literature, and outlines the critical social variables involved in any transference from public to private provision. This is followed by a section that discusses the major conceptual distinctions between each form. In the third section a more detailed study is made of one specific form of privatisation and how it interrelates with the closely associated process of market deregulation. The final substantive section undertakes a critical review of one major contribution to the literature on privatisation in which a specific form of the process is subjected to detailed study.

4.1 The Implementation of Privatisation Policies: Descriptive Accounts:

One advocate of privatisation writing for the Adam Smith Institute has identified no less than 21 different methods of privatisation (Pirie 1985 cited in Ascher 1987, 6 see figure 4.1). Writing from an adversary point of view, on behalf of the trade union movement, Hastings and Levie (1983, 12) describe privatisation as covering a "*multitude of sins*" from which they list eight forms and indicate that they by no means exhaust all the options available. Following Bailey (1987) and Starr (1987), Boston (1988) has described privatisation as comprising a "*multitude of policy initiatives*" such as:

1) the termination of public programmes and the disengagement of the state from particular activities or responsibility - load shedding;
2) the privatisation of funding through user-charges while retaining public provision;
3) market deregulation or liberalisation;
4) the sale of publicly-owned assets such as state-owned enterprises, land or capital items;
5) the contracting out of services once performed by public agencies to private firms (Boston 1988, 1).

Regardless of the number of 'forms of privatisation' there may be, enumerating them is of little assistance to analytical debate as presented. The critical question, which immediately arises, is whether

there are any qualitative distinctions between them, or do they just represent different stages on a continuum from a public to a private sector economy? In the subsequent section an attempt is made to isolate the main conceptual differences between various forms of privatisation. In so doing it lays the groundwork for a more detailed look at one particular form of privatisation in a subsequent section of the chapter.

FIGURE 4.1: Forms of Privatisation

Method	Example
selling the whole	Amersham International
selling complete parts of the whole	English Channel Ferry Services
selling a proportion of the whole	British Petroleum
selling to the workforce	National Freight Corporation
'giving' to the public	British Telecom discounts
'giving' to the workforce	Hoverspeed
charging for the service	NHS prescription charges
contracting out	local authority and NHS services
diluting the public sector	road funding
buying out existing interest groups	council house sales
deregulation by voluntary associations	aviation (CAA)
encouraging alternative institutions	University of Buckingham
making small scale trials	freeports
repealing monopolies	bus and coach services
encouraging exit from state provision	social security (private pensions)
vouchers	transport tokens
curbing state power	private searches
divestment	British Gas
applying liquidation	hospitals
withdrawal	quango activity
right to private substitution	the 'right to repair'

Source: M. Pirie, 1985: *Privatisation*, Adam Smith Institute, London, taken from Ascher K. 1987: *The Politics of Privatisation*, Macmillan, London.

4.2 An Analytical Framework for Identifying Forms of Privatisation:

It was established in the first chapter that, in its simplest form the difference between the public and private sector economies rests on the respective distinction between collective (social) and commodified provision of goods and services. For any economy, capitalist or otherwise, to reproduce itself over time three processes must occur; production, exchange and distribution. Goods and services (understood as products of human labour in all economies where there is at least a rudimentary division of labour, or as commodities in capitalist ones) must be produced, exchanged, and distributed for sustained societial reproduction. In the case of production, the critical factor is the ownership of the means of

production - whether it is predominantly private as under capitalism or public (ie social) as under socialism.

Once produced goods and services must be exchanged in order to be consumed. This process can take place either through a market mechanism or by some collective body which in a capitalist economy would take the form of the state sector bureaucracy. Where a market is operative, the funding or financing of goods and service provision is through the value exchange process. On the other hand, with a bureaucracy provision has to be funded from taxation or fees, levied on a collective basis.

Finally distribution or allocation can be through market based competition on an individualised basis, or by regulation (legal requirements and conditions) imposed by the collective apparatus of the state. The difference between these two conditions is essentially one of control. In individualised commodity provision the only control is that of supply and demand in the market - the 'invisible hand' - whereas in collective provision the control is distinctly visible in the form of statutory legal requirements or political coercion.

It is suggested here that the three variables - ownership, funding and control, which corresponding respectively to the production, exchange and distribution, are fundamental to identifying different forms of privatisation. These variables may therefore be regarded as forming the basis of the critical differences between the public, state, regulatory sphere and the private, market, competitive sphere. The conceptual distinctions between the sphere of collective provision and the sphere of commodity provision may be represented schematically as in figure 4.2. It may therefore be reasonable to conclude that all privatisation processes must involve changes to one or more, if not all, of the three variables identified.

FIGURE 4.2: The Conceptual Differences between Collective and Commodity Provision

Privatisation Variables	Sphere of Collective Provision	Sphere of Commodity Provision
Ownership	Public	Private
Funding	State	Market
Control	Regulation	Competition

In the following analysis the prime intent is to identify possible ways by which collective provision can be transformed into individual provision. Without losing any conceptual rigour the terms, public, state,

and regulation are used interchangeably and likewise for private, market, and competition. Hence a publicly owned enterprise is taken as identical to a state owned enterprise and regulatory control to state control. The term government is reserved for the administrative arm of the state and includes the democratic elected parliament and the appointed administration (bureaucracy). The problem to be pursued is to determine, and distinguish between, the various ways in which public sector institutions can be privatised using these variables.

4.3 The Analysis of Forms of Privatisation:

Possibly the most obvious, and indeed the most publicised, way of privatising state assets is to sell them in the market place in which case they then become privately owned and market funded through the 'user pays' principle. Examples range from state owned property such as housing to an entire national railway system. By undertaking asset sales the state relinquishes its role as both owner and funder of the goods and services provided.

4.3.1 The Selling of State Assets and Enterprises:

This process may take place in a variety of ways. First, the sale may be made to an existing private sector enterprise, usually which ever one offers the highest market price. The state owned enterprise may either be sold as one single operating unit, or else in various parts, to a series of different buyers. A second and perhaps better known, if not more controversial, way for the state to sell its assets is by creating a new enterprise through the establishment of a public limited company. This may be achieved either through a management/worker 'buy out' of the enterprise or through a public share subscription. In the latter case the assets being offered for sale are often those of state owned industries occupying a monopoly position in the market place for their products. Sometimes these industries are termed 'natural' monopolies because economies of scale indicate optimum efficiency from a single provider structure'.

The privatisation of natural monopolies has generally been a problem for advocates of privatisation. As there is the ever present likelihood of just creating a private monopoly out of a public one this is seen to negate the desirability of privatisation since there is no competitive market in existence for attaining economic efficiency. In the absense of market competition various regulatory bodies have had to be established to monitor performance. Perhaps the most prominent examples are the formation of OFTEL and OFGAS in the UK to regulate, repectively, the operations of privatised British Telecom and British Gas.

Various methods have been advanced by which the monopoly status of certain state owned enterprises may be ended upon privatisation. At risk of loss of scale economies, the enterprise might be regionally fragmented so that the entire service provision for the nation state is based upon a smaller number of privatised units. Competition would then be stimulated from comparison of costs and levels of service provision across regional boundaries. Another method is to retain the single nationwide service provision, but to fragment the enterprise along infrastructural lines. This particularly applies in the case of industries based on networks such as railways (tracks), electricity transmission (grids) and telecommunications (networks). The enterprise would be split to form one authority, possibly still state owned, which would own the network, and would then sell the rights to any private sector operator who wished to provide a service.

Another means of privatising state owned enterprises is to fragment the services provided between different private sector operators. Railways, for example, might be privatised through the formation of separate private companies for, say, inter city passenger traffic, urban commuter services, provincial services, and railfreight. As an alternative to selling an enterprise as a single operation, any one, or mixture of, the above means of regional, infrastructural and service fragmentation may be implemented. For example, the privatisation of Japanese National Railways (JNR) has mainly involved a regionally and service based separation of the system. Sakita (1989, 29) reports that JNR, the only nationally owned rail corporation in Japan was broken into 12 private corporations on April 1st 1987:

> The 12 private corporations, collectively called the Japan Railway (JR) Group, consist of six regional passenger railways, one freight railway corporation, one Shinkansen (bullet train) corporation, one account settlement corporation, one research institute, one computer and one telecommunication corporation (Sakita 1989, 29).

In the UK there is still much debate on the most appropriate one of the above methods by which the privatisation of British Rail may be achieved (see *Modern Railways* 1988, 658, 1989, 225).

The divestment of state ownership and funding need not always come by the state selling assets. Instead a leasing or franchising arrangement may be entered into with the private sector. The ownership rights would not then be transferred in perpetuity and the state would be in receipt of rental income instead of proceeds from asset sales. To take the example of state owned commercial forests, the cutting rights to the timber may be

sold or leased competitvely to the highest bidder, while the land itself remains in state ownership, a policy that is being seriously considered in New Zealand at the time of writing. Similarly public hospitals, either in their entirety or just some of the beds within them ('pay beds' in the UK), may be leased, rather than sold, to private and voluntary sector operators. State owned transport services might lease out the provision of catering services to private sector operators as British Rail has already done in certain instances. Again with public hospitals, any surplus capacity in catering and laundry facilities may be leased for private sector operation.

The changing of the ownership and funding arrangements of state enterprises by their sale, or lease, to the private sector can clearly result in major changes to the socio-spatiality of service provision. In each case however where provision by private enterprise is involved, there is possibility of bankruptcy and/or corporate merger. These processes are said to be instrumental in ensuring the alleged superior efficency of private over state sector enterprises. The result of mergers and bankrupties might be that goods and service provision is compromised and consequently the privatisation of the state may not always extend as far as selling the assets and enterprises. Alternatively the state owned enterprise might be in such a financially unattractive situation that no private business operation would be interested in its purchase, a not infrequent occurrence. Returning to the case of JNR, Sakita (1989, 29) states that the state owned enterprise had accumulated debt totalling US$285 billion prior to its privatisation. Clearly before any such enterprise can be sold it would require radical 'restructuring'!

4.3.2 The Commercialisation and Corporatisation of the State Sector:

Where a government wishes to ensure continuity of supply, but still divest itself of financial costs, public ownership may be retained but market funding resorted to by the introduction, or enhancement, of user charges. The state remains owner but not funder. In practice few state owned industries or institutions are completely 'free at the point of use' but those that are are usually in the welfare or consumptive sector of the economy and comprise institutions like publicly provided schools and hospitals. Normally though, charges are imposed on the consumers of state publicly provided goods and services but at lower than market rates, such as with prescription charges for medicines, university fees or urban (commuter) train and bus fares[2].

The levying of these charges moves the source of funding from public (state) to private (individual) payment and the 'user pays' principle

starts to operate even though the charges levied may leave the major proportion of the funding to be derived from state sources. The move from public to private funding can be extended even further to the point at which the entire cost of the goods and services are met by the consumer through the state charging the full market (commercial) rate rather than providing them free or at a price below the full cost recovery level. Hence the funding may be entirely from private sources while the asset concerned is still owned, and hence the service provided, by the state. In addition to a move to generate revenue from users, the process is nearly always accompanied by efforts to reduce expenditure, particularly labour costs through attrition and redundancy.

The process described here, which does not necessarily require any change to the ownership of the assets, may be referred to as the commercialisation of the state sector. From 1987 onwards much of the state sector in New Zealand underwent such a process the end point of which was termed 'corporatisation'. This saw the transference of certain government departments, funded largely from state taxation revenue, to market funded but still publicly owned enterprises (corporations).

According to Gregory (1987, 119), corporatisation is "*a move to establish publicly owned enterprises which are expected to act as if they were private ones*". The essential rationale behind the policy was to separate commercial (profitable) from social (non-profitable) objectives as these had been formerly indistinguishable when the enterprises operated as full departments of state. On this basis the costs of providing services on the basis of social need would become 'transparent' and the government might then make what would amount to a political decision on whether to continue funding such a service.

Some of these newly formed New Zealand corporations have subsequently been sold to the private sector and currently the sale of others is still pending. The critical difference however between corporatisation and the selling of assets to the private sector is that in the former case the enterprise itself cannot be bought and sold in the market. It is not therefore subjected to the competitive conditions existing in the market place. For this reason, according to Boston (1988, 7), advocates of free market policies regard corporatisation as being little better than an "*unsatisfactory half way house*" to privatisation. From this standpoint privatisation would mean nothing less than the sale of the enterprise to the private sector. Nevertheless corporatisation may still justifiably be called a form of privatisation as the funding is comprehensively privatised with the move towards market based sources of finance.

4.3.3 Privatisation by Contracting Out:

Notwithstanding the analytical differences between privatisation by asset sales or commercialisation, a basic similarity is that both forms of privatisation are intended to generate revenue simply by making the privatised form of delivery more profitable than hitherto. In the first case revenue comes from the proceeds of a 'one off' sale and in the second it comes from the receipt of a regular dividend on commercial operations. There are cases however where it may not be possible to generate revenue for the state if the users of the goods or services provided are not able to pay a market price for them. Should the government deem, for whatever reason, that it is either economically necessary or socially desirable to maintain provision then the privatisation alternative is to 'contract out' to the private sector, a process sometimes known as 'private contracting'.

This may occur with areas of state activity like refuse collection and hospital services, where termination of the services would threaten the overall well being of the populace and possibly create political unrest. Wherever contracting out occurs private sector operators provide the required goods or services while the state still acts as funder. The assumed duty of the government is then merely to see that services are provided, rather than for the state to be the actual provider. Private contracting, in effect, amounts to a process in which the state remains funder but not the provider of goods and service provision.

The cleaning of schools, hospitals, government offices and many constructional activities are often performed by the private sector under contract from the state. This is the well known 'provider/funder' split. As a much fuller discussion of contracting out is presented in a later section, further analysis of this form of privatisation will not be pursued here. Suffice to say by way of summary that by altering the ownership and funding variables from public to private and from state to market respectively three different forms of privatisation can be identified. State asset sales or leasing involves changes to both ownership and funding, commercialisation/corporatisation changes the funding only while contracting out only alters the ownership or provision arrangement. These changes are presented in tabulated form in figure 4.3.

4.3.4 Privatisation of the State and Deregulation of the Market:

In each of these three processes of asset sales, commercialisation and contracting, the effect of privatisation depends critically upon the extent of market deregulation. The process of deregulation involves the government removing many, though hardly ever all, legal restrictions (ie

FIGURE 4.3: Analytical Distinctions between Three Different Forms of Privatisation

	Private Ownership	Public Ownership
Market Funding	Sale of Assets	Commercialisation Corporatisation
State Funding	Contracting Out	Public/State Provision

controls) on private capital competing with publicly owned enterprises.

There are two principal control mechanisms that the state can maintain over the operation of the market which may be termed, quantity and quality licensing. Deregulation through eliminating, or at least reducing quantity licensing, involves the ending of restrictions limiting the number of entrants into a market. This does not usually extend to relaxing, still less ending, quality licensing which regulates the conditions under which entrants may operate in the market. While the transport industry may be deregulated to the extent that anyone can compete for a share of the business, regulation still governs the issuing of heavy vehicle driving licences, loading factors, and other issues deemed to be in the public interest. Much controversy however surrounds the question of whether the ending of quantity licensing also compromises the effectiveness of the quality licensing, particularly as health and safety standards may be affected.

The essential rationale behind deregulation is to introduce (more) competition into the market place and thereby break the hitherto restricted competition or monopoly that exists in either the state or private sector. In both Britain and New Zealand, the transport industry was one of the first to be deregulated through allowing greater freedom for private road hauliers, both passenger and freight, to compete with state owned railways systems. By allowing Mercury to compete for some of the business of British Telecom the UK government went someway towards deregulating the telecommunications industry. Airlines may be similarly deregulated under what has been termed the 'open skies' policy which has been vigorously pursued in the USA, and partially introduced into New Zealand in 1987 with the entry of the Australian domestic carrier Ansett to compete alongside Air New Zealand.

Deregulation policies can also be applied to other than physically existing enterprises. Finance capital may be deregulated by such means as

the state relaxing, exchange controls, restrictions on the granting of banking licenses, and rules governing the investment of capital overseas. Similarly the labour market may be deregulated by the state abolishing, or at least weakening, legislation governing the payment of minimum wages, nationally based occupational or industrial wages agreements, holidays and long service leave entitlements etc.. The intention is to ensure that labour costs will more readily reflect the laws of supply and demand and growing competition will result between units of labour for a given number of jobs.

By deregulating the market, potential is opened up for private enterprise to operate where only state owned enterprise existed before. This occurred with the establishment of the privately owned University of Buckingham in the UK and with the Anglo-French Channel Tunnel for which private capital was raised through forming the public limited company, Eurotunnel. Such enterprises have hitherto usually been considered the sole preserve of the state, which therefore has maintained a monopoly control over their establishment. In a similar vein, an increasingly common result of a deregulated market is the 'joint (public/private) venture'. Here an entirely new company is formed, based on capital from both the public and private sector. For example, the New Zealand Railways Corporation has recently joined the Freightways Group in a joint venture dubbed Freightways Express (Stott 1988, 220).

Markets can be deregulated without any changes to ownership or financial structures of state institutions themselves. Schools and hospitals, for instance, may still be publicly owned and provided 'free at the point of use' even if the market for the private provision of these establishments is deregulated. By deregulating the market there is simply a relaxation of the controls over the entry of private capital into areas of formerly state monopoly. The principal effect, however, is an arbitrary increase in the proportion of private to public sector provision. This could take the specific form of an increase in the number of private hospitals, schools, or transport services compared to public ones. Usually however the operation of a competitive deregulated market necessitates changes to the structure of the state sector in order for it to be competitive with the private sector. Conversely the state sector may be privatised without necessarily deregulating the market for the products of the industry being privatised.

4.3.5 Privatisation and Public Service Retrenchment:

Apart from the process of 'load shedding' (Bailey 1987, 139), the situations just discussed cover all the forms of privatisation in the

typology produced above by Boston (1988, 1). Arguably load shedding has been involved in all the above processes since the state has effectively 'load shedded' in respect of either its ownership, funding, or controlling functions. Yet in all instances there is the tacit assumption that the state 'load sheds' in favour of private ownership, market funding and competition between enterprise owners (providers). This however may not necessarily be so as some goods and services may not be able to be produced profitably by the private sector, in which case the private sector does not produce them at all.

Privatisation through selling, leasing, or commercialising a state owned enterprise, or part thereof, may not be possible if the enterprise does not have sufficient potential revenue generating capacity in the form of making a real return on investment. In other words if it is simply not profitable. Similarly privatisation by contracting out, while structurally possible, may not produce a sufficient expenditure reduction for a fiscally strained government. The only, and indeed ultimate, option is for the government to close down the institution concerned. Typically this affects the state's welfare sector and may take the form of the closure of public hospitals, rural railway services, schools, or post office and retail banking facilities. Writing over a decade ago, Moseley (1979) has detailed the affects of such closures in rural areas in terms of residents' accessibility to alternative sources of provision.

To take the example of rural railway services, these may be, in the first instance, replaced by private bus companies, a process that has become known as 'bustitution' in Britain. The substituting bus companies might either operate the service on a self financing basis or on contract from the state. But if not profitable, or no government contract is forthcoming, then no substitute service may be provided at all. Under these circumstances potential consumers have to find their own means of travel either individually (eg cycling) or collectively (eg car sharing).

Where there is both market 'failure' and state 'abstention', production has to be undertaken by the domestic sector (the household) or by charities and religious institutions in the so-called voluntary sector. Residential child care is an example of a service being provided in each of the public (local authority), voluntary, and private sectors. The termination of public transport services, whether privately or publicly provided, necessitates households having to find their own personnal forms of transport. While not strictly privatisation since there is no market involvement, there are nonetheless marked social consequences. Writing a decade ago, largely before the current phase of privatisation, Hillman and

Whalley (1980) detail the adverse effects on people of rural railway closures in Britain. Communal or voluntary forms of organisation may also develop from public service retrenchment in the form of car pools, women's refuges and self-help housing groups (see Wekerle 1984).

Summary

In summary then it may be said that privatisation requires changes to ownership and funding arrangements while deregulation necessitates changes to the state controls operating on the market exchange process. For both privatisation and deregulation to occur then all three variables identified - ownership, funding and control - need to be changed. Figure 4.4 shows in tabulated form the interelationship between privatisation and deregulation.

FIGURE 4.4: Interrelationship between Privatisation and Deregulation

	Sale of Assets	Corporatisation/ Commercialisation	Contracting Out	Deregulation
Ownership	x		x	
Funding	x	x		
Control	x	x	x	x

x = change from public to private

To the extent that privatisation is, in part at least, a response to state fiscal stress, the different processes identified can be grouped according to either their state revenue generating or their state expenditure reduction capacity. Selling enterprises, leasing the rights of service provision, and commercialisation of institutions each generate revenue for the government. Contracting out to the private sector and service retrenchment are means of expenditure reduction. To a certain degree there is temporal sequence to these processes. State enterprises usually have to be commercialised or corporatised first so that they can be made attractive for sale or lease while contracting out can amount to being an intermediary stage towards complete service retrenchment.

In the above discussion it has been assumed that each of the processes identified as a form of privatisation necessarily results in privatisation. This may not however always be the case. A state owned enterprise may be sold but to another state owned enterprise albeit in another nation state[3] rather than to the private sector. Hence not all state asset sales amount to privatisation. A similar situation holds in the case of contracting out. As this form of privatisation, and its geographically uneven

development, is to be subjected to a detailed empirical case study, the remainder of this chapter is devoted to further analysis of contracting out.

4.4 Contracting Out and Privatisation: Some Further Conceptual Clarification:

Since the late 1960s, and even before in some cases, contracting out has been seen by many government authorities as being a means to trim the seemingly ever growing size of the state sector. Although contracting out exists extensively in the private as well as the public sector, the latter case is particularly noteworthy as there is a direct effect upon goods and services which the community as a whole depends upon. These range from law enforcement and health care to public transport and refuse collection. Rather than being specifically sold to the private sector, these services may be contracted out, in which case they are effectively privatised without the risk being incurred of the services disappearing altogether through the likely lack of private profit. The main purpose of this section is to identify the conceptual differences between the process of contracting out and that of privatisation. This involves the need to make qualitative distinctions between three terms which tend to be used almost interchangeably in the privatisation literature; contracting out, private contracting and competitive tendering.

4.4.1 Contracting Out, Private Contracting and Privatisation:

Contracting out has been described by Ascher (1987, 7) as occurring, "*where one organisation contracts with another for the provision of a particular good or service*". While this may accurately describe the process involved, the main problem with this definition is that it does no more than just describe. No indication is given of the conceptual foundation which underlies the contracting out process. Viewed more analytically it may be said, as an above section has indicated, that contracting out requires an institutional separation of the provision from the funding of goods and services. The institution or enterprise that continues to be the funder becomes the contractee and the institution or enterprise that takes up the role of provider becomes the contractor.

Under such an arrangement either the provider or the funder, or indeed both, may be in the public or the private sector. For example, it was pointed out in the previous chapter that, in the USA, some city authorities have been contracting with other local body authorities (as well as private operators) to provide some of their municipal services; a case of one state institution, as funder, contracting out to another state institution to be provider (see Miller 1981). In a similar way

many private sector enterprises contract out to other private companies for goods and services they either cannot, or wish not, to provide themselves. A private bus company contracting out its vehicle maintenance requirements to a local private garage would be a typical example.

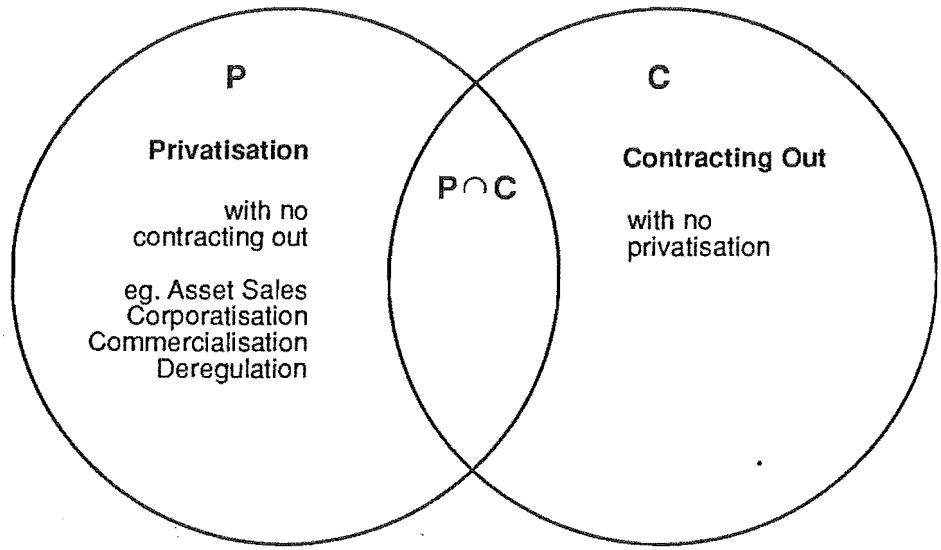
Private contracting occurs when the contractee (funder) is in either the public or the private sector but the contractor (provider) is specifically in the private sector. If this latter condition does not hold the contracting out is not private, as in the first of the two examples just given. But for private contracting to amount to privatisation an additional condition must hold. There must be a transfer from public (state) to private (market) provision. This requires a public institution to contract out to a private business (contractor). In this case the contractee must be in the public sector and the contractor in the private sector. Privatisation therefore is a special form of private contracting which is in turn a special form of contracting out. Conversely of course contracting out is itself a certain form of privatisation to be distinguished, for example, from state asset sales and commercialisation. So just as contracting out does not necessarily imply privatisation, neither does the latter necessarily imply the former as illustrated in the Venn diagram below (Figure 4.5).

4.4.2 Contracting Out and Competitive Tendering:

Contracting out, whether it be private contracting or specifically privatisation, can be achieved in two principal ways. The first is by the contractee entering into a negotiated price contract with just one contractor in which case the contract price is then settled by mutual agreement between the two. This situation usually, but not always, occurs when one enterprise or institution has a monopoly in the market for certain goods and services. The second way is to tender out by inviting enterprises to compete with each other for the contracts, but this can only arise when there is more than one potential contractor in the market. With competitive tendering the contractee would normally opt for the most competitive bid rather than negotiating a contract price. This may not always be the lowest bid as the standard and reliability of the contractors can also be considered in awarding contracts.

Tendering out then may involve the same structures as contracting out with regard to the relations between provision and funding, but unlike the latter it requires a competitive market to be effective. Hence contracting out does not automatically involve tendering out. Again however the converse also applies; tendering out need not always result in contracting out. The management of the service to be tendered out may submit their own

Figure 4.5 Venn Diagram Showing the Relation between Contracting Out and Privatisation



{P} = {all forms of privatisation}

{C} = {all forms of contracting out}

{P ∩ C} = {privatisation by contracting out}

{P - C} = {privatisation with no contracting out}

{C - P} = {contracting out with no privatisation}

tender, alongside the others, to the institution which employs them. If this 'in-house' tender is competitive relative to the others then it may be awarded the contract in which case the contract price becomes the budget for the service to be provided. Public hospital ancillary services have often been provided under this arrangement in the UK and, to a much lesser extent, in New Zealand.

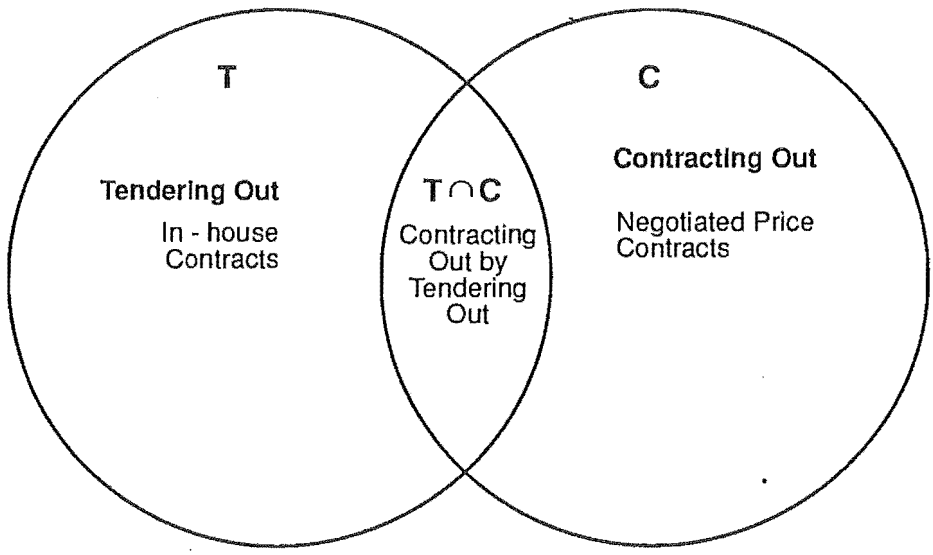
In this situation there is tendering out but no contracting out as there is no funder/provider split. Under negotiated price contracting out this could not occur as no competitive bidding is involved in which the in-house labour force could be involved. In short then, contracting out need not imply tendering out while conversely, the latter need not require the former. Excepting the special case of contracts being secured in-house, competitive tendering may be regarded as a restricted form of contracting out. Again the relationship between the two may best be illustrated in another Venn diagram (Figure 4.6).

4.4.3 Competitive Tendering and Privatisation:

Owing to the highly specialised division of labour throughout modern industry no public or private sector concerns can produce internally all their required goods and services. Scale economies may simply render impractical the acquisition of necessary labour skills and technology to provide these requirements and so both state and private organisations have to rely on contracting out to other organisations. For example public hospitals cannot usually satisfy much of their regular requirement for certain domestic supplies, medical and engineering equipment. Tendering, or contracting, out for this could not then be regarded as privatisation if only because no in-house work force was ever involved in the first place and so there was no transference from state to market provision. So, as has already been seen in another context, contracting out, whether or not by competitive tendering, does not necessarily amount to privatisation (Figure 4.7).

Nevertheless when these kind of services required by the state are put out to competitive tender, the potential opens up for 'rationalising' the labour force employed by the contractors in order for them to be competitive. In this case it is in the private sector where the labour force is 'rationalised' through the greater competition in the market arising from the state sector putting out its requirements to competitive tender. A somewhat different situation arises when a state institution provides its own goods and services and then decides, for whatever reason, to tender out their provision to some other public or private institution. Public hospital catering services, or local authority bus services and

Figure 4.6 Venn Diagram Showing Relation between Contracting Out and Tendering Out



{T} = {all forms of tendering out}

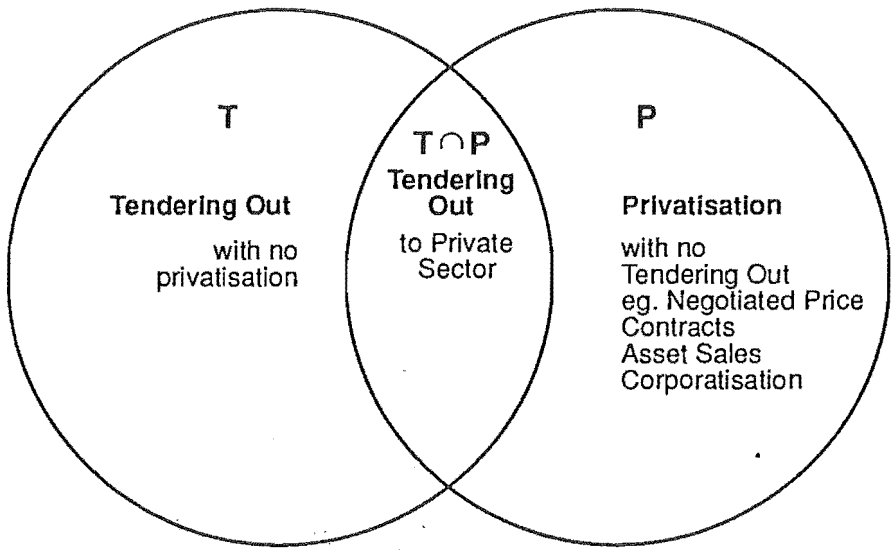
{C} = {all forms of contracting out}

{T ∩ C} = {contracting out by competitive tender}

{T - C} = {in-house contracts}

{C - T} = {negotiated price contracts}

Figure 4.7 Venn Diagram Showing Relation between Privatisation and Tendering Out



{T} = {all forms of tendering out}

{P} = {all forms of privatisation}

{T ∩ P} = {privatisation with competitive tendering}

{T - P} = {tendering out with no privatisation}

{P - T} = {privatisation with no tendering out}

refuse collection for example, may be put out to competitive tender in this way.

This situation is particularly relevant to the process of privatisation as market forces are then being brought into the state institution itself and therefore there is a direct impact on the labour force that was formerly employed by the state. Unless the contract is awarded in-house, there is always a change of employer and the possibility of redundancy and redeployment, all of which is especially pronounced in labour intensive industries. Even with the contract being awarded in-house these possibilities are only reduced and by no means eliminated (see for example Milne 1987). So where there is competitive tendering for services in which no in-house labour force has ever been employed, the effect of the process is to 'rationalise' the work force already in the private sector by increasing competition there.

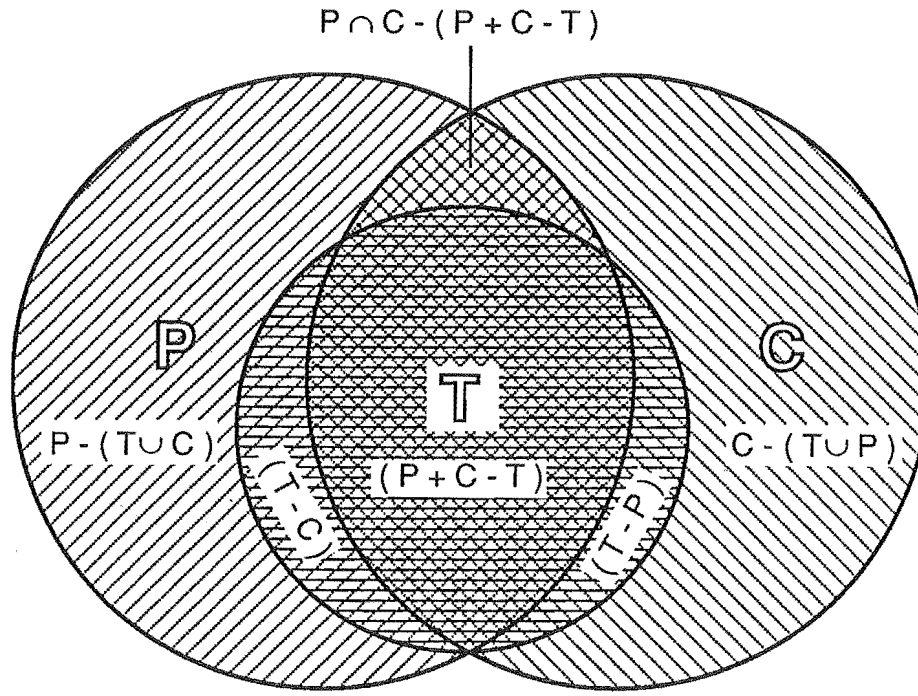
In the second case, where there is an existing in-house labour force, competitive tendering brings the forces of market competition to bear on the state sector workforce. The result of the tendering process is that the workforce could end up being either transferred to the private sector or remaining in the state sector. As to which option eventuates depends upon which sector offers the most competitive contract price. A comprehensive illustration of the interrelationship between the concepts just discussed is presented by superimposing all the above Venn diagrams as in figure 4.8.

Summary

Privatisation in respect of contracting out requires an act of transference from state (public) to private (market) provision of goods and services that are customarily provided by the state. Where the contracting out is by tendering out, then privatisation need not necessarily amount to a transference from state to private provision since the competition engendered is intended to bring market mechanisms into state institutions. Market provision may occur without the service concerned being technically (ie legally) private. Similarly if the private provider is a monopoly then, while technically private, there is not any meaningful market provision. The critical point in the privatisation and contracting out debate is not so much whether the provision is by private or public institutions, but whether the forces of market competition operate. Only in this latter case will the labour force and the operation of the service itself be 'rationalised' in the way that privatisation policies hope to achieve.

Having established some conceptual clarity upon which to examine the

Figure 4.8 Venn Diagram Showing Relation between Contracting Out, Competitive Tendering and Privatisation



{ ℙ }	= {all forms of privatisation}
{ ℂ }	= {all forms of contracting out}
{ 𝕋 }	= {all forms of tendering out}
{ P } - { T ∪ C }	= {privatisation without contracting or tendering out}
{ T - C }	= {privatisation by tendering out but without contracting out; in-house contracts}
{ P + C - T }	= {privatisation by contracting out but with tendering out}
{ P ∩ C } - { P + C - T }	= {privatisation by contracting out but without tendering out; standard or negotiated price contracts}
{ T - P }	= {contracting out with tendering out but without privatisation; goods and services which the state cannot provide itself}
{ C } - { T ∪ P }	= {contracting out without tendering out or privatisation; negotiated price contracts with another state institution}

process of contracting out, attention can be turned towards applying this analysis to a particular empirical situation and within the theoretical frameworks stablished in the previous chapter. The particular case selected is the New Zealand public hospital system where the contracting out for certain ancillary services has become well estabilised, especially in the 1980s. Prior to this it is worthwhile to review some contributions to this debate. An especially significant one is that of Ascher (1987).

4.5 Privatisation by Contracting Out: The Contribution of Ascher (1987):

The Politics of Privatisation: Contracting Out Public Services (Ascher 1987) presents a detailed analysis of developments in contracting out in UK local authorities and in the National Health Service (NHS). The significance of this work to the study of privatisation arises in at least four ways.

The first is that, rather than presenting a general overview of the entire privatisation process, Ascher gives a detailed account of one specific form of privatisation; that of contracting out to the private sector. Secondly, she provides one of the few full-length accounts of privatisation that is not devoted primarily to the sale of state assets. The work therefore address a substantial gap in the privatisation literature. Thirdly, attention centres entirely on service provision at the scale of local government which includes the provision of public hospital ancillary services. This restriction in focus is advantageous insofar as it permits a much more detailed analysis of the privatisation process than would be possible in a more general work. The final point arises directly out of the previous one and is perhaps the most important for this thesis. By centering attention on locally provided services, Ascher's work raises, but fails to address, the issue geographical variations in privatisation that may occur within a single nation-state. Through undertaking a critical review of this contribution, a context is provided for the empirical research in the following chapters.

Much of the development of contracting out in the 1980s, as detailed by Ascher, is set within the context of rising militancy of public sector unions and industrial disruption in local authorities and public hospitals in the late 1970s and early 1980s. The election of a Conservative central government in 1979, and again in 1983, is presented as a crucial development in the contracting out of hospital services through the subsequent pressure that this Government placed on hospital administrations to implement the policy of contracting out. The major services involved, known collectively as ancillary services, included

domestic, catering and laundry services. With local authorities on the other hand the impetus for contracting out is presented as stemming mainly from the local level administration itself, consequent upon the election of Conservative controlled councils.

Along with Dunleavy (1986a), Ascher (1987, 249) finds wanting the thesis of what she terms the 'New Right'. Based on public choice theory, and detailed in chapter two above, the New Right argument is that government administrators are budget maximers and therefore reluctant to privatise the services which they administer. This contention is disputed by Ascher on basis of the generally limited opposition she found to privatisation exhibited by these people in both the NHS and the local authorities. However, what she calls the 'traditional left' or trade union contention that privatisation is an overt political attack on workers and their organisations is also not sustained. This finding is based on the grounds that the central government did not pursue privatisation with as much vigour as it might have done, as it only insisted on tendering out services rather than contracting them out. Ascher (1987, 259) concludes instead that contracting out must be seen as, "*a natural adjustment to an over reliance on public sector provision, a reaction to two decades of poor management and overly powerful trade unions*".

Although a wealth of information on contracting out within an empirical situation is given by Ascher, at least four major criticisms can be levelled at her account. The first relates to the theoretical framework adopted. Despite Ascher's objections to the New Right's budget maximisation thesis, her own conclusion is still set very much within the terms of public choice theory, in which the public sector is seen as inherently problematic. In respect of her conclusion on the reason for contracting out, what one may ask is "natural" in the adjustment to private provision, in what way was there an "over reliance" on public provision and by what criteria were the trade unions "overly powerful"? Answers to these questions are not evident.

Clearly within the terms of public choice theory and its focus on the dysfunctionality of public bureaucracies these points may be perfectly valid, but, again with reference to chapter two, this body of theory only presents a partial explanation of social phenomenon. Virtually no consideration is given by Ascher to either the macro-economic context in which the contracting out process occurred (eg rising unemployment, recession and deindustrialisation) or to changes in the role of the welfare state in Britain. Where these issues are neglected, only a partial explanation of the privatisation process is possible as earlier

work in this thesis has demonstrated.

A second level of criticism of Ascher arises form the conceptual understanding of privatisation. The inadequacy of her definition of contracting out has already been referred to earlier in this chapter. A further problem relates to her rather confusing use of the terms, contracting out and competitive tendering. Thus chapter six is entitled, 'Competitive Tendering in the NHS' (my emphasis), and chapter seven, 'Contracting Out in Local Authorities' (my emphasis). Why the difference? Both processes seem to have occurred in each organisation.

It appears, without being made explicit, that all health authorities were required, by central government, specifically to tender out services, but not necessarily to contract them out if the in-house tender was more competitive than outside private sector ones. However at the time that Ascher wrote, local authorities were at liberty to contract out their services either by competitive tender or by negotiation with whom ever they pleased. Moreover in the case of local authorities there do not seem to have been any in-house tenders submitted. Such matters are not made clear in the text and the two concepts appear to be used rather arbitrarily. A much more rigorous analytical approach is required to the differences between contracting and tendering together with a much greater degree of specifity in the subsequent use of the terms.

The third level of criticism can be directed at the lack of attention given to the structures and constraints of hospital and local service provision. Throughout Ascher's account attention focuses almost solely on the role of interested parties almost as if they were autonomous actors on the scene. So rather than just citing "two decades of poor management" it would have been more illuminating if Ascher had detailed the structural conditions under which management decisions were made and highlighted what may have been contradictory pressures upon the managers concerned.

Hardly any discussion is presented on the structure and funding of the NHS and its various services, such as the ancillary ones under discussion. Even just some simple flow diagrams or charts detailing the chain of command would add greatly to the clarity of the work especially for any one not familiar with the organisation of the NHS or UK local authorities. It is almost impossible from Ascher's account to ascertain who in the hospital or local civic administration makes the decisions with regard to contracting out services and who exercises the authority.

The fourth main criticism and, from a geographical perspective, possibly one the most prominent is the almost total neglect of any

consideration of regional variations within the overall process. Nowhere is the reader told how many different health and local authorities were in existence or which ones contracted out their services, and if so which services? Neither is any information provided on variations between hospital authorities in terms of population characteristics of catchment areas, or of the size and type of hospitals involved in contracting out. The only suggestion found of a regional basis to contracting out, and then only mentioned in passing, is in the passage, "*Union officials publicly attributed this geographical shift* [in the focus of industrial action] *to the fact Northern authorities began to implement the Government's tendering policy rather late in the day*" (Ascher 1987, 122). No explanation is offered in respect of this observation.

It is also apparent from Ascher that in some of both the NHS and local authorities there was no tendering or contracting out at all. This is revealed, albeit indirectly, when she states, "*authorities which have never contracted out are particularly keen to minimise the risks of future disruptions in key services*" (Ascher 1987, 124 emphasis mine). But no indication is given of where these authorities are located or how many fall into this category. Moreover it is not clear from the text, both in this passage and elsewhere, whether the authorities that Ascher is referring to are NHS or local ones or both. Another interesting observation is that, "*only about half of all NHS services had been put out to tender by the end of 1985 and local authority services are unlikely to go out in significant volume until 1987 at the earliest*" (Ascher 1987, 133). Similar questions arise in respect of the geographical basis of the development of this form of privatisation. That there is not a single map offered anywhere in the 293 page text, not even one showing NHS/local authority boundaries, does make it very difficult to ascertain the overall extent of the contracting out from both a spatial and sectoral perspective.

Arguably Ascher's inattention to the uneven spatiality of the privatisation she describes has cramped the scope of the theoretical frameworks she offers to explain the process. She argues that "overly powerful" trade unions were one of the main causes of contracting out in the first place. However the work of Elliot and McCrone (1984), detailed in the previous chapter, has shown that high levels of class conflict can restrict employer initiatives to reduce working conditions through policies such as privatisation. Regional variations in the industrial militancy of the work force could then have had an important, if not decisive, affect on the contracting out process. As Ascher (1987, 188) comments, "*pressure from the unions led at least two health authorities, Sunderland*

and York, to temporarily suspend their tendering programmes". Although it is not clear whether these authorities did eventually tender out their services, the possibility should be considered that labour militancy might have inhibited privatisation initiatives as much as enhanced them.

By taking a regionally sensitive approach, as for example adopted by Massey (1984), it would seem that spatial, and temporal, variations in levels of class struggle may have had a crucial mediating role in the uneven development of privatised service delivery. While it is indisputable from Ascher's account that there has been a major assault on workers' employment conditions in the services *in toto*, the process appears to have been far from spatially uniform. Regrettably this matter is given virtually no attention.

Before concluding this section on Ascher, it is worthwhile to consider, if only very briefly, a few other contributions on the contracting out of public services. All exist in the form of individual papers but are worth citing if only for the added poignancy they give to the critique of Ascher. Milne (1987), Sheaff (1988) and Cousins (1988) each present comparative case studies of changed working conditions for hospital ancillary workers resulting from contracting out, new management structures and poor industrial relations. The selectiveness of these studies however does not provide any basis for ascertaining the overall geographical extent of this form of privatisation in the British NHS. Within the geographical literature, contributions to the study of privatisation by contracting out have come from Pinch and Witt (1987) and Mohan (1988) both of whose work is set within the broader context of the general 'restructuring' of public hospital services in Britain.

The former work focuses exclusively on one single region, but the latter considers privatisation in the broader context of England. Although Wales and Scotland are excluded for reasons not stated, the spatial unevenness of contracting out ancillary services is suggested by Mohan (1988) in citing the National Audit Office (1987) to the effect that:

> DHAs [District Health Authorities] in the South East [of England] have contracted out more services than in the North and West while inner London DHAs were initially slower than their suburban counterparts to put services out to tender (Mohan 1988, 457).

This observation however is not subject to any further discussion or explanation.

On the basis of these reviews it is clear that many questions remain unanswered and much scope exists for geographical research into the socio-spatiality of privatisation. The importance of these criticisms for this thesis lies in the direction they give to the empirical research undertaken

in the following chapters. The shortcomings in the work of Ascher and others provide a useful reference point from which to approach the analysis. It is with a view to progressing in this direction that the contracting out of New Zealand public hospital ancillary services is offered as a case study. In the light of many of the issues just raised, the aim is to present further theoretical understanding of geographically uneven privatisation.

Conclusion:

In discussing the qualitative differences between forms of privatisation, this chapter has presented an analytical framework for identifying the various processes involved in transferring public goods and service provision to the private sector. It has also been seen that whether through the sale of state owned enterprises, the commercialisation of government departments or the contracting out of public services, distinct regional and sectoral variations may develop in the way that services are provided. Privatisation cannot therefore be analysed as a unitary process.

For state sector activity in the productive sector, spatial fragmentation can occur when enterprise operations are regionalised with a view to establishing market competition between them. It is acknowledged that regionalisation tends to occur whenever an industry has its operations decentralised and that privatisation may be non existent. Rather the point to emphasise is that where privatisation has been pursued, there is invariably a regional fragmentation of production.

In the case of public services, the extent of their privatisation through contracting out can vary substantially between and within each local state authority. In addition to the spatial differentiation of institutions and enterprises there is also the social fragmentation accompanying the process. Enormous potential opens up for significant spatial and sectoral changes in the working conditions of those employed in the privatised industry and the levels of service provision to community. While considerable attention has been given in the literature on privatisation to describing the various socio-economic effects of the process, there remains a distinct dearth of theoretically informed analyses of the spatially uneven nature of its implementation.

Footnotes:

1 This conception of natural monopoly is the one used in neo-classical economics. Within Marxian theory, monopolies are only 'natural' to the extent that they derive this status from the inherent tendency of capitalism towards expanded reproduction. The operation of scale economies is only made possible by the ever growing centralisation of capital.

2 According to *Rails* (April 1988, 202), "*The principality of Liechtenstein, worried about mounting pollution, has become the first country in Europe to offer free public transportation in a move to discourage private commuting*". In Fiji, South Pacific Sugar Mills Ltd., used to offer the only free passenger train service in the world, until completely abandoning the service in 1978.

3 Although no empirical examples of this appear to exist, the potentiality for it was present with the possibility of the sale of the Shipping Corporation of New Zealand to the state owned Italian shipping line, Lloyd Triestino. The Corporation was finally sold to the (private) British based company, Blueport ACT.

CHAPTER 5

The New Zealand Public Hospital System and the Provision of Ancillary Services

This chapter provides an introduction to the empirical investigation of the contracting out of New Zealand public hospital ancillary services. The previous chapter attempted to show that different forms of privatisation can have different geographical impacts and it was noted that very little academic attention had been given to analysing the spatially uneven development of any particular form of privatisation. Also apparent from the last chapter is that whatever form of privatisation one considers, it has occurred across a wide variety of different industries. The geographically uneven development of privatisation may therefore be analysed either in the context of a particular industry or a particular form of the process itself.

In chapters two and three the theoretical frameworks that purport to explain the implementation of privatisation policies were developed without reference to any particular industry, nation state, or form of privatisation. This chapter looks at one specific industry - that of public hospital provision and in particular the organisation of its ancillary services. Within the terms of the theoretical frameworks established previously any industry in which privatisation has occurred could be selected for detailed analysis, but there are at least three reasons for choosing public hospital provision.

The first, which has already been mentioned in the previous chapter, refers to the political sensitivity of health care privatisation. In most western capitalist countries a publicly provided and funded hospital system has been seen by most sectors of society as being an integral part of the welfare state. The privatisation of the system has tended to generate much apprehension amongst the public, to the extent that some governments which have been enthusiastic implementers of privatisation policies in other areas of state activity have felt the need to claim that the system is 'safe in our hands'. Be this as it may, a study of public hospitals in the New Zealand context reveals that privatisation through contracting out ancillary services had become entrenched in the system well before the mid 1980s when the major initiatives to privatise, or at least to corporatise the state sector, came to the fore. Moreover, and somewhat paradoxically, the privatisation of these particular hospital services has caused very little political controversy.

The second reason for studying the public hospital sector is to address the question as to why certain services or sectors of industry may

be privatised much earlier than others. While this observation may also apply outside the hospital sector, the industry provides a striking example of sectorally uneven privatisation. The review of Ascher (1987) in the last chapter showed that the potential exists for the contracting out of public hospital services to the private sector to develop very unevenly across geographic space. Consideration though must also be given to the probability that certain services or sectors of industry, at any one time, may be privatised to a far greater spatial extent than others. A study of public hospital privatisation can show the process to be both spatially and sectorally fragmented.

The third reason for analysing the privatisation of public hospital ancillary services arises from the value such a study may have in explaining the geographically uneven privatisation of other local authority services. At the time of writing major reorganisation is taking place in New Zealand's local government and urban public transport, all of which is expected to result in extensive contracting out of services to private and voluntary organisations. This privatisation may be expected to be a very spatially uneven process across the country as a whole. A study of contracting out on a nation wide scale is therefore timely in the New Zealand context in view of likely forthcoming developments in public service provision and, as already noted, the existing history of hospital service privatisation.

Although the case study selected is centred on the New Zealand hospital system, it is anticipated that whatever conclusions are ultimately drawn, they will have theoretical significance across a broad section of industries and need not be confined to any one nation state. Limitations on time and resources have restricted the empirical work in this thesis to just one form of privatisation in one particular sector of an industry.

Much of this chapter is devoted to showing the administrative structure of the New Zealand public hospital system in general and the ancillary services in particular. In order to provide a broader context for the discussion, the chapter starts by examining the ways in which different forms of privatisation may be applied to public hospitals. A second section examines the rationale behind moves to privatise and generally 'restructure' public hospital provision in the context of the New Zealand system. In the third section attention is centred more specifically on the administrative structure of the New Zealand public hospital system and is followed by a section dealing exclusively with the ancillary services. The final part presents a short case study showing the different ways in which ancillary services can be provided within the

same public hospital system. Throughout the chapter emphasis is given to showing how the social (ie hierarchical) dimension of the hospital system interacts with the spatiality of service provision.

5.1 Privatisation and the Provision of Public Hospital Services:

In most western countries there exists a mixture, in varying proportions, of private and public sector involvement in hospital care as demonstrated by Navarro (1985). All the forms of privatisation identified in chapter four may apply to transitions from public to private provision. Nowhere, however, has the public system been completely dismantled and, as already seen, it is almost universally held by governments, and the public at large, to be the bedrock of the welfare state. Nevertheless hospital care has not been immune from privatisation and may be increasingly subjected to the process during the 1990s.

Attempts to privatise a public hospital system can take one of two possible directions. The first is to increase the proportion of private to public sector involvement in hospital care, while the second seeks to reorganise the remaining public sector hospital system in such a way that it more closely resembles the operations of the (private) market sector. In practice these two policy goals may be pursued simultaneously. The expected result would be a reduction in the state's financial support for hospital care. In the following two sections each of these two policies is considered in turn.

5.1.1 The Growth of Private Hospital Care:

The growth of private over public hospital provision may occur simply through the state failing to provide sufficient resources to cater for the demand for services. There may therefore, using the terminology of Hirschman (1970), be an 'exit' from the public hospital system by some service users who take their requirements to the private sector and thereby stimulate the growth of private hospitals and medical insurance companies. Writing over a decade ago on the New Zealand situation, Fougere (1978), in what he terms, *Undoing the Welfare State*, has demonstrated this 'exit' effect and claimed that:

> ...dissatisfaction [by the public] has given rise to massive exit and an undetermined degree of suffering in silence. Each year since its introduction, more and more people have taken out private medical insurance. At the same time, the number of people obtaining surgery in private hospitals appears to be steeply increasing, particularly in Auckland (Fougere 1978, 410).

Writing more recently on New Zealand, Barnett and Barnett (1989) have detailed the growth of private hospitals since the 1950s. They emphasise the rapidity of this growth in recent years, especially for long term

geriatric care where, by 1986, companies or small entrepreneurs controlled 43 percent of all beds (Barnett and Barnett 1989, 89). In the USA private hospital growth has been even more marked and since around 1970, Bohland and Knox (1989, 54) report on the growth of private 'multihospital organisational structures'. A distinctive feature of this trend, as observed by Salmon (1985), has been the increasing ownership of hospitals by large scale corporate capital as opposed to the former preponderance of small scale individually or charitably owned institutions. According to Salmon (1985, 396), "*the growth in numbers and beds since 1970* [in the for profit hospital systems] *contrasts dramatically to the contraction of the 'not for profit' and government segment of the industry*".

Regarding the institutions in the latter two categories, Whiteis and Salmon (1987, 48) comment that recent US government policy has encouraged their closure through the reduction of federal reimbursement for treating the medically indigent. As a consequence a growing number of them have become either unable, or unwilling, to care for the kind of patients they previously took in (Whiteis and Salmon 1987, 48). Citing the work of McLafferty (1982), they report that since the mid 1970s, "*data has shown a growing phenomenon of economic crisis and hospital closures among institutions serving the poor and minority populations of major US cities*" (Whiteis and Salmon 1987, 53).

In discussing privatisation of the British National Health Service (NHS), Mohan (1989, 115) comments that, since the early 1970s, there has been a "*greater market penetration by multinational hospital chains, including United States based corporations*". Rayner (1987, 210) attributes this growth to locally owned private and charitable hospitals retaining a low fee structure in line with the NHS 'pay beds' and having staff payment rates similar to NHS rates. The result of such policies was that these hospitals did not have sufficient financial resources to respond as quickly as the multinational hospital chains to the expanding market in the late 1970s (Rayner 1987, 210). A similar process has occurred in the New Zealand private hospital system where Barnett and Barnett (1989, 89) have identified a clearly discernable trend towards multinational, multihospital investment.

Where there exist state restrictions or regulations on the extent of private hospital provision, the growth of the private sector can be considerably enhanced simply by the government deregulating the market for this service. Private sector hospital growth may be encouraged still further by the existence of government subsidy which has often taken the form of tax relief for private medical insurance contributions. Mohan

(1989, 114) notes that in the UK, as in New Zealand, controls on new private hospital developments have been relaxed in the 1980s although both Governments stopped short of tax concessions for insurance contributions.

An even more direct way to increase the private to public ratio of provision is for public hospital authorities to sell off or lease hospitals to private, and voluntary sector operators. Alternatively, or additionally, public hospitals, in either whole or part, may simply be closed down. The private or voluntary sector is therefore required to meet the outstanding service demand. Not only does this increase the proportion of private to public hospital provision but additionally there may be an increase in the use of private resources as service users could have to travel much further than previously to the nearest remaining public hospital. Far from multinational capital being involved in this case, many small individually owned hospitals or even domestic households assume a share of what may have formerly been public provision as institutional (hospital) care is transferred to community (private and voluntary) care.

5.1.2 The Commercialisation of State Sector Hospital Care:

Whatever the increase in private provision, and whatever the scale of capital involved, a residual public sector must always exist if a socially acceptable level of provision is to be made for those without sufficient resources to avail themselves of private care. Growing costs of medical care together with increasing restraints on state expenditure has encouraged governments to restructure the state sector so that it operates according to market criteria. The aim therefore has been to introduce a more competitive environment for public hospitals to operate in.

Certain options present themselves. Hospitals could be establised on a full cost recovery basis similar to state owned enterprises and forced to compete for business alongside private sector hospitals. Fees for service, financed either individually or through third party insurance, would be the means of funding. Through such a 'corporatised' form of provision the state can still be the provider of services but it no longer retains its funding role. The main problem with this arrangement is that it involves the public sector charging market prices for its services and so the difficulty of providing for the medically indigent still remains. As far as is known no country yet operates such a system.

When the ensuring of a universal access to hospital care across all social classes is deemed necessary the public hospital system may be reorganised so that it still retains its role as funder of service provision. By contracting out services to the private sector, particularly

through a process of competitive tendering, the state ensures the provision of all services without itself being the provider. By placing all service provision and staff on a contractual basis the foundation can be established for providing an internal market for the public health system. Advocates of private sector provision maintain that such a system yields greater accountability, transparency and economic efficiency. To date however no such large scale contracting out of hospital functions seems to have occurred and the process has been largely restricted to certain activities like the ancillary services or to the provision of geriatric beds. Nevertheless, in countries like Britain and New Zealand, moves to contract out a greater range of services and personnel than hitherto are under serious consideration.

5.1.3 Theoretical Explanations for Public Hospital Privatisation:

Two interrelated processes appear to be operating in hospital care privatisation. One is the reduction in the level of public sector provision and the other is the move to provision by large scale multinational capital. Each is considered in turn. In the first case the explanation, according to Whiteis and Salmon (1987, 53) is that reduced public hospital provision is, "*part of a larger move toward removal of public goods and services from certain population segments; the unproductive poor, working class, aged, and disabled*". Without specifically referring to the Marxist thesis of O'Connor (1973) discussed in chapter three, their explanatory analysis follows a similar theme. They argue that:

> this dismantling of health care institutions to exclude the 'unproductive' population comes at a time when there is a rerouting throughout the international economic order of substantial amounts of formerly public monies into private accumulation, in an effort to shore up sagging profit levels (Whiteis and Salmon 1987, 53).

An explanation more in line with Tieboutian public choice theory detailed in chapter two would contend that the increasing public demand for hospital care outstripped the financial ability of the state to supply it and thus stimulated a consumer led 'exit' to the private sector (Califano 1981). A Weberian managerialist perspective on the other hand would suggest that the cause of private sector growth lies in governments trying to rid themselves of public responsibility towards those least able to 'exit' to the private sector (Fougere 1978). Whatever the relative merits of these explanatory frameworks, all three would probably be in agreement that there has been a significant growth in the size of private capital investment in hospital care. This brings the discussion to the second of

the two processes referred to above.

The growth in capital investment may be attributed to the increasing technological complexity involved in the hospital service. The result has been that, on the one hand, greater levels of capitalisation are required for hospitals while, on the other hand, some small community hospitals lacking such investment potential have been squeezed out of existence as Whiteis and Salmon (1987) have shown. It is predominantly in the low technology, geriatric, and terminal care provision that individual and voluntary/charitable hospital ownership has prevailed, and indeed proliferated in some countries such as New Zealand (Barnett and Barnett 1989). Even in this low technology sector however large scale capital is becoming more involved as Harrington (1984) reports in the case of the USA.

Public hospital systems may therefore be either sold, leased, corporatised and/or contracted out in efforts to privatise service provision. As mentioned earlier, the provision of hospital ancillary services has been one of the first sectors of public hospitals to be privatised while the privatisation of other areas of the hospital system has been a much more recent development. In the case of New Zealand many of the forms of privatisation just discussed are still only at a feasibility stage.

Throughout the 1980s, however, public hospital services in New Zealand and many other countries became increasingly difficult to provide. This has brought about much political and economic pressure for substantial changes in the form of service provision beyond just privatising ancillary services. In the next section these difficulties are discussed in the New Zealand context, although many of the problems identified are by no means confined to that country.

5.2 The Public Hospital System under Stress: The Case of New Zealand:

The concern of many governments over hospital care, or more generally health care, during the last two decades has rested primarily on its increasing cost. At least four reasons, applicable to a variety of countries, have been cited for this increase in health expenditure. In brief these are, first the growing public expectation of what health care can deliver, second the removal of financial barriers to access, third the increased complexity of medical technology and, finally the ageing of many countries' population which has led to greater demands for hospital treatment. New Zealand, as the government commissioned Report of the Health Benefits Review Committee (HBRC 1986) made clear, has by no means been exempt from these general trends. Public hospital expenditure in particular has come under considerable fire as, according to the HBRC

(1986, 87), it has been responsible for only 10-20 percent of patient care but takes up 60-80 percent of total health expenditure in many countries including New Zealand.

From the mid 1970s most OECD countries faced slow economic growth together with growing fiscal deficits. Accompanying these adverse economic conditions and state fiscal stress was the realisation that increased health expenditure was not resulting in parallel improvements in mortality, life expectancy or any other measure of health status (HBRC 1986, 87). This has been particularly pronounced in New Zealand in the case of infant mortality where in the 1930s this rate was the lowest in the world but since then the country, "*has been overtaken by most OECD countries and now has a low ranking on this indicator*" (HBRC 1986, 28).

Only two years after this report another one appeared, again commissioned by the government, and produced by the Hospital and Related Services Taskforce (HRST 1988). This report, which has become more commonly known as, 'The Gibbs' Report', after the Taskforce's chairperson, has identified some rather more fundamental problems with hospital care. The principal one was that of access, or lack thereof, to the system due to the existence of unacceptably long waiting lists for treatment. According to this report:

> As far as the public is concerned the greatest failing of the present hospital system is access. Waiting lists for treatment are one of the public hospitals' most obvious problems. People must wait for admission for treatment unless they are victims of accidents or develop acute conditions such as appendicitis (HRST 1988, 6).

The report also identified a series of what it termed 'management deficiences' (HRST 1988, ch 4). More specifically these related to a lack of productivity incentives for staff, a lack of management information and accountability due to almost non-existent management accounts and costing systems. Largely following from this, there was seen to be a decided lack of cost consciousness on the part of staff (HRST 1988, 21). In short the two reports maintained that health care outputs, in the form of treatment and health status, were not matching the (ever increasing) inputs, specifically in the form of costs.

Both these reports, but particularly the second, advocated a much more competitive, market-oriented system of hospital provision while still keeping the major proportion of funding public. For the HBRC (1986, 116), the recommendation was to move either, "*to a system with competitive HMOs* [Health Maintenance Organisations'] *or to one involving the state as principal funder contracting for at least some of the services it needs*".

With the HRST (1988, 26) the main proposal was to establish a structure that introduced a clear separation between the funder (the government) and the providers of health services. "*This separation*", claimed the HRST, "*enables a market to be created in which prices are set by modified competition between hospitals*" (HRST 1988, 26). Waiting lists might then be reduced through the hoped for productivity increases with privatisation.

It is perhaps a measure of the political sensitivity of public hospital and health care provision that the New Zealand government did not, at least openly, accept the recommendations of these reports. Nevertheless continued constraints on hospital funding and increased costs of provision have resulted in some of the recommendations of these reports being adopted by the hospital authorities. This has led some community and trade union groups to see the so-called Gibbs' report as having received at least a *de facto* acceptance by policy makers. Be this as it may, both this, and the previous section, clearly show that New Zealand has by no means been immune from the general world wide tendency to privatise hospital services. It would though be erroneous to regard all current public hospital privatisation and more general restructuring as having only arisen in the light of the above two reports.

One sector of the New Zealand public hospital system above all others - the ancillary sector - has for long been the subject of privatisation, market competition and the separation of the funder from the provider by contracting out to the private sector. While the HRST could refer to a general lack of cost consciousness on the part of hospital staff, this shortcoming has certainly not been in evidence in the ancillary sector, at least since the mid 1970s. Before examining this sector in closer detail though it is first necessary to look at the overall structure of the public hospital system. This enables one to see how the system, since its inception, has provided hospital services.

5.3 The Administration of the New Zealand Public Hospital System:

5.3.1 The Provision of Services:

The administration of hospitals in New Zealand has, for over a century, been in the hands of regional authorities known as hospital boards. The severe economic and social problems associated with the Depression were responsible in large part for the election in 1935 of the first Labour Government (Fraser 1984, 60), which introduced a public 'free at the point of use' hospital care system. In the Social Security Act of 1938 free inpatient treatment at public hospitals became a universal entitlement. One important consequence of this was the growth in demand for treatment which saw public hospital financial requirements become

stretched to the point at which former local authority and charitable funding was no longer adequate, even with state subsidy, to maintain a service (Ward and Asher 1984, 91). Following the passing of the Hospitals Act in 1957, the central government assumed the entire financial responsibility for the public hospital system from 1st April 1958, while still devolving the administration to the regional level.

Largely as a direct consequence of hospital boards having to rely on central government for their funding, the latter has always had a significant degree of control over the operations of the former. In order for the elected government to ensure that a hospital system is maintained and controlled there exists a centrally organised structure, or bureaucracy, called the Department of Health. This administrative structure is comprised of appointed managers, rather than elected politicians and headed by a Director-General. The function of the Department has been to:

> advise the Minister [of Health] on, or determine in respect of boards, the extent and standard of hospital and allied services, the building requirements to provide these services, the numbers and levels of the main groups of professional staff to be employed, the appropriate financial grants, and measures of financial assistance to be given to private hospitals including loan finance (NZOYB 1985, 177).

In keeping with this, the Department of Health has issued from time to time a variety of instructions to all hospital boards relating to service provision.

The number of hospital boards in New Zealand has varied over the years as the changing distribution of population has brought about some amalgamations. From a peak of 47 hospital boards in 1909, there had been a reduction to 37 by 1950, 31 by 1970 and 29 by 1974. These boards initially comprised members and nominees of existing local authorities until the amendment of the Hospitals and Charitable Institutions Act of 1909, after which they were directly elected every three years at local council elections (Ward and Asher 1984, 91). They each comprised 8 to 14 members who between them represented different local council constituent districts within each hospital board district. The members of these boards conduct their business through being subdivided into various committees, typically comprising one for finance, one for works and buildings, and another for health services. These committees report monthly to the meetings of the full board in order to make final policy decisions.

The 29 hospital boards in existence in 1974 remained until mid 1988 when some further amalgamations took place. The size of these boards varied enormously, both in spatial extent and population covered, from that

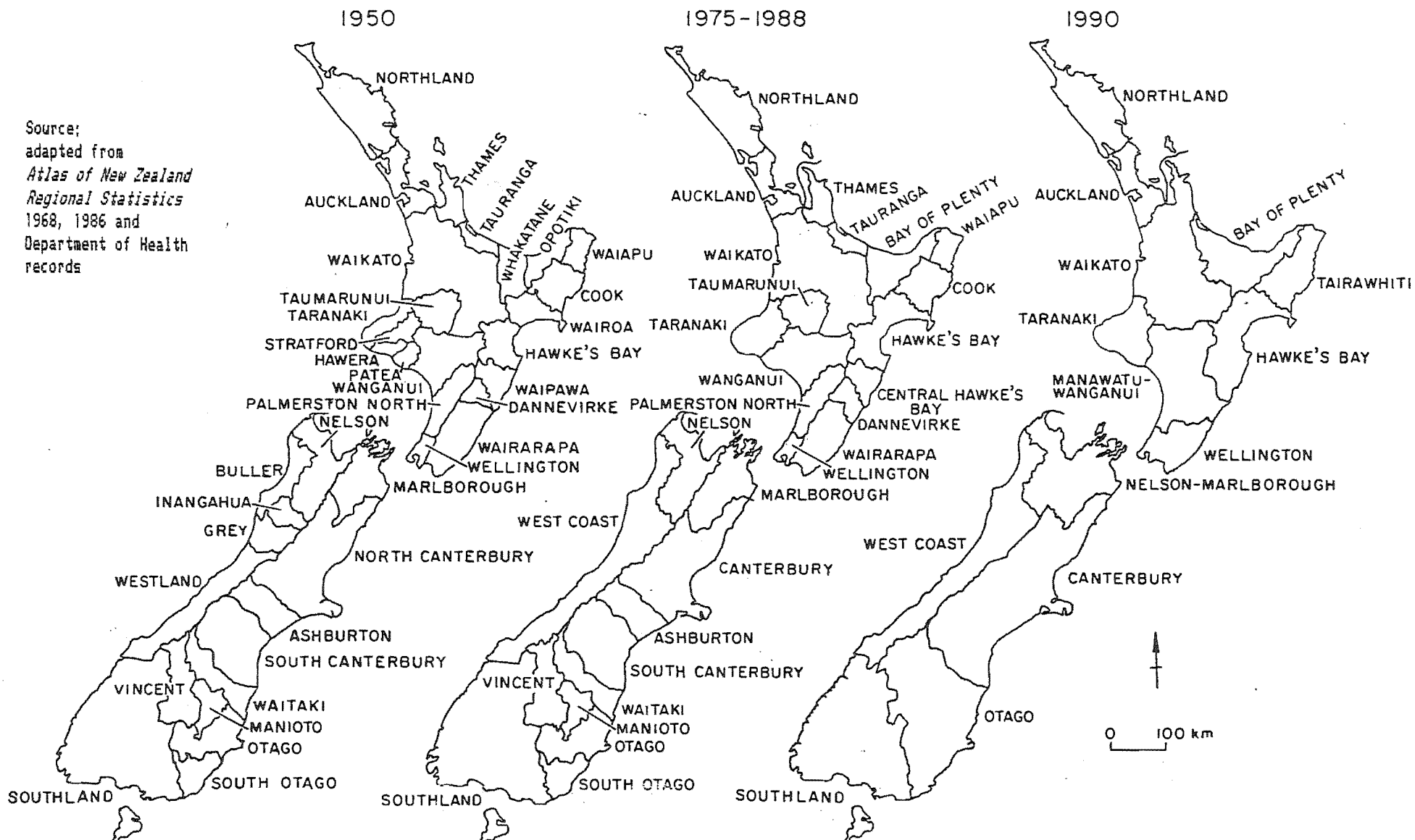
of the Auckland Board to the Maniototo Board (serving in 1988, 913,000 and 2,290 people respectively). In 1983 the government passed the Area Health Board Act which provided for the gradual replacement of hospital boards by area health boards. Members were still to be elected under the same circumstances as previously but the new structure assumed responsiblity for primary health care, a function that hitherto had been performed directly by central government acting through the Department of Health. The first area health board was formed in Northland in 1985 and by the end of 1989 all pre-existing hospital boards had been transformed into 14 area health boards as shown in the maps in figure 5.1.

The main statutory requirements that central government impose on the elected members of hospital boards is that they, "*provide, maintain and staff such institutions, hospital accommodation and medical, nursing and other services as the Minister of Health considers necessary*" (NZOYB 1985, 178). With the recent formation of area health boards the government imposed a slightly broader function upon them that extends to all health services in the wider community. Under either system the provision of hospital services by a board, required the appointment of a specific management structure to execute board policy in a similar way to the Department of Health in respect of the central government. In the hospital board system this structure was divided into a managing triumvirate comprising a chief executive, a medical superintendent and a chief nurse although in some cases the third position was subordinated to the second. By the end of 1989 these three management areas had been condensed into one with the formation of area health boards in which the position of general manager became established to oversee the provision of all health services both primary and secondary.

Within the original hospital board structure, the board members had a considerable management role, insofar as they could, 'hire, fire, and promote' all levels of staff and generally oversee the provision of all services. In practice however it was usually only the most senior management staff that were specifically appointed by the board with the responsibility for the recruitment of lower levels being delegated to other management staff. Virtually all issues relating to management policy had to be placed before the elected board members for approval. Under the succeeding management structure this managerial role has been all but eliminated. According to the Minister of Health in *Health, A Prescription for Change* (nd, 17):

> the role of the [area health] boards is to develop policy and specify services to be provided in their regions. The responsibility for implementing that policy falls on the board's

Figure 5.1 New Zealand Hospital and Area Health Board Districts, 1950-1990



Source:
adapted from
Atlas of New Zealand Regional Statistics
1968, 1986 and
Department of Health
records

chief executive. The elected members of the boards have no management function (my emphasis).

Much controversy remains though over whether it is possible or even desirable to dichotomise between management and policy (Martin 1989, 7), and the precise role of the area health boards in this matter is still uncertain. In respect of staff appointments, the board members may only be responsible for appointing the general manager who then takes on the responsiblity for all staffing positions. Provision also exists for the central government to appoint a, still to be decided, number of members to each area health board and so these bodies will no longer comprise solely elected members. Democratic representation by election from the community is therefore to be reduced in favour of bureaucratic management by appointment, a move that has mainly been justified on the grounds of increasing complexity of hospital management and the need for specialised expertise.

This tendency may be countered to some extent by members of area health boards receiving an enhanced payment under the new system in the hope that a broader cross section of the community will be encouraged to stand for office. In this case at least the quality, if not the quantity, of democratic representation will be increased. As will be seen in a subsequent chapter, the tendency under the original system was for members to belong to those social groupings which did not have to engage in full time wage labour, and therefore the boards had only limited community representation. Regardless of the degree of democratisation, the respective roles of government, elected hospital/area health boards and the public has been summarised by Martin (1989, 8) as follows:

> a board is the agent of its area population; it has a general mandate to do whatsoever it believes necssary to meet the health needs of its area; and it is accountable to its area electorate. the Minister is the 'banker' and by statute the 'regulator' of the Board's behaviour and is accountable to the New Zealand electorate for his exercise of both these roles.

5.3.2 Direct or Contract Provision for Services:

In neither the hospital nor area health board structure is there, or was there, any requirement made by central government for boards themselves to provide the services they required. The responsibility of boards has been to see that services are provided, whether directly by employing staff themselves or by engaging outside contractors. If the latter option is adopted the boards have to comply with certain regulations over the letting of contracts as laid down by the Department of Health. Perhaps the most significant of these is that contracts should not be entered into for more than three years. A major difference

between hospital and area health boards is that, with the former, the elected members had to give approval for contracting out services. Under the latter, superceding structure, boards have no management function and decisions on contracting out rest solely with the general manager.

When adopting the contract option boards cease to be the employers of the labour force and providers of the services although they still act as funders of the services. If, as is usually the case, the contracting out is specifically to the private sector (ie private contracting) then the provision of the service and the labour force employed is transferred from the public (state) to the private (market) sector. In privatisation by contracting out of hospital services there are then four parties involved; the central government, hospital/area health boards, the labour force and the contractors.

Summary

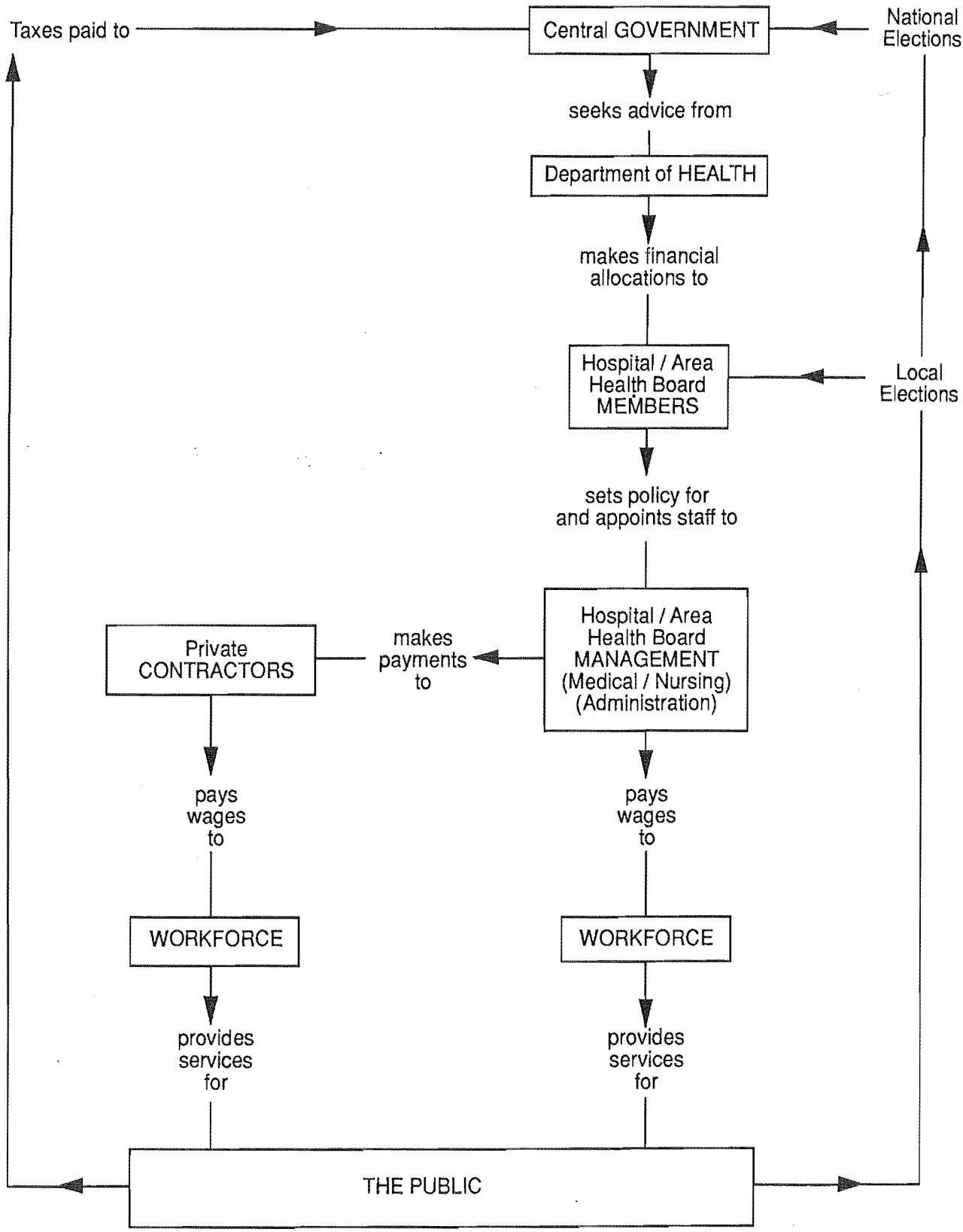
In spite of the differences between hospital and area health boards the overall structure of public hospital service provision in New Zealand may be summarised as follows. Central government, through the Department of Health allocates, funds to the boards and discharges to them the responsibility for seeing that hospital services are provided. The board members appoint a management team, or just a general manager, who in turn must decide either directly to employ a labour force to provide hospital services to the public, or else to engage contractors to do so. The taxation paid by the public to the central government gives the necessary funding for the service provision and the election of the board members is intended to ensure the public's democratic representation (figure 5.2). As contracting out for service provision in public hospitals has been mostly for ancillary services, a closer study is merited on the ways in which these services are administered.

5.4 Public Hospital Ancillary Services:

5.4.1 The Classification of Ancillary Services:

There are few clearly defined divisions amongst hospital services in New Zealand and nowhere is the term 'ancillary' given precise definition in this context. The usual dictionary definition of the term is 'subordinate, subservient and auxiliary' and in terms of hospital services it usually refers to services that provide 'support' to the primary function of hospitals - that of treating patients. Sometimes called, *A Forgotten Sector* (Smith 1969), ancillary services have not historically attracted much media or academic attention except in more recent times in the context of industrial disputes.

Figure 5.2 The Financing and Administration of the New Zealand Public Hospitals by either Private (Contract) or Public (Board) Provision



One of the major sources of statistical information on New Zealand public hospital is *Hospital Management Data* which was published annually by the Department of Health's, National Health Statistics Centre between 1975 and 1988[2]. In this publication, hospital services were classified under six main headings; general treatment, diagnostic, hotel, engineering and maintenance, administration, and community. The first category comprises medical, nursing and para-medical (eg physiotherapy, pharmacy, psychology) services while the second covers pathology and X-ray services. The term ancillary has generally been applied to what *Hospital Management Data* calls 'hotel' services, although sometimes, engineering, maintenance and administration may also be included under the term.

The word ancillary, support or hotel may then be taken as simply different labels for the same group of services. There is however a further subdivision of this group in *Hospital Management Data* into that of housekeeping, laundry and dietary services. The latter two are capable of reasonably clear distinction and are complete services in themselves. Housekeeping however has been presented as a generic term to cover a variety of unspecified services which do not fall within the scope of the other two. The task of identifying precisely the services that comprise housekeeping has been made difficult as the Department of Health has not provided any clear guidelines to boards on this matter. There has therefore been much scope for discretion on the part of individual boards in recording data on these services. The identification of these services remains a crucial issue here, for by far the majority of ancillary services that have been contracted out are included under this classification.

Empirical research with hospital boards has revealed that the major components of housekeeping, in terms of costs and personnel employed, are that of domestic cleaning and orderly or portering services. The term 'domestic' has often been prefixed to 'cleaning' in boards' correspondence with contractors in order to distinguish it from other more minor or specialised housekeeping services like window cleaning and vermin control. Sometimes boards just refer to their domestic services in which orderly services may, or may not, be included. Nevertheless, orderly services in terms of employment classification have always been quite distinct from that of domestic cleaning even if there has sometimes been an overlap of duties. For the purposes of this work, housekeeping services are taken to refer to both domestic and orderly services and, where laundry and dietary services are also being referred to the term ancillary is used. In short:

ancillary/support/hotel = housekeeping + dietary + laundry

= domestic + orderly + dietary + laundry

5.4.2 The Provision of Hospital Ancillary Services:

The provision of most hospital services, including the ancillary ones, has usually taken place at two spatial scales; the regional and the local. At the former scale is the central administrative apparatus for all hospitals (173 in 1988) and institutions within the 29 regions (districts) covered by each board. The local scale is founded on the individual hospitals with their on site institutional administration in which managerial authority is devolved down to the workforce at the point of service production. Within each board there has existed different levels of management with the number of levels depending very much upon the size of the board. In what follows a typical structure is detailed and it should be realised that no two boards have ever been identical in their management stuctures.

With the hospital board structure, as it existed prior to 1989, ancillary services, for the most part, were administered under the ultimate responsibility of a board's chief executive. This generally applied to domestic, orderly and laundry services. From what has generally been seen as their close connection with patient treatment, dietary departments have come under the medical superintendent of each board. Beneath both of these top positions came the respective deputies together with various other senior management staff such as the director of finance and the chief engineer.

At the next level of administration were a number of executive officers who each had responsibility for service provision in their respective sectors for all hospitals and institutions within the board's district. For the ancillary services, overall management has usually been divided between the board's supplies officer who has covered domestic and orderly staff and the chief dietitian for the kitchen staff. In general then the central or regional administration has comprised three levels of managerial hierarchy: the chief executive, the deputy and the executive officers heading the various services. Similar levels of management existed on the medical side.

Below this level of administration, managerial authority has been spatially, as well as socially (ie hierarically), diffused to the various localised hospitals, where provision for housekeeping and dietary services became the responsibility of a hospital manager and head dietitian respectively. Intervening between these positions and the labour force have been various departmental heads and supervisors each having successively decreasing levels of authority. This basic form of managerial structure would have been replicated at all hospitals within

each board.

Although the system just described is largely hypothetical it has nevertheless been more applicable to the larger boards, since in many of the smaller ones the management positions identified have often been combined. For example, the supplies officer's and hospital manager's responsibilities were in some cases assumed by the chief executive alone. In this case there would have been no central or regional administration as such since the board may only have comprised one hospital and the entire management structure was located within it. Nevertheless the socio-spatial context of ancillary service provision in New Zealand public hospitals can be presented in terms of a general overall administrative structure. Starting from the central government's Department of Health in what may be termed 'the core' (Wellington), there is a pyramid like diffusion of power and authority in two principal stages. The first is towards the regionally based hospital boards and the second is the continuation from there towards the locally based institutional administrations which govern the labour force in 'the periphery' (figure 5.3).

Where either housekeeping (domestic and orderly) or dietary services or both have been contracted out the management responsibilities from that of executive officers downwards were considerably reduced as some, and may be all, staff who would otherwise have been administered by them were instead employed by a contractor. If an entire service was contracted out there would then have been no departmental head or supervisors in the board's employment and the functions of the (local) hospital manager and (regional) executive officer would also have been much reduced in this particular area. In some cases a contract supervisor has been appointed by boards to oversee standards of service provision. This position has usually been subordinate to the supplies manager and has replaced the administrative functions that lower levels of management had when services were provided by the boards.

When contracting out has been resorted to, the main line of communication between board and contractor has normally been from the projects or supplies officer to the branch manager of the contracting firm concerned. As many supplies for hospitals, from food to fuel, have always had to be secured by contract from the private sector it has often been appropriate for ancillary services to be the responsibility of the same manager who deals with all other board contracts (figure 5.4). To illustrate the separate administrative structures between boards in respect of contracting out ancillary services it is instructive to take

Figure 5.3 The Social and Spatial Structure of New Zealand Public Hospital Service Provision

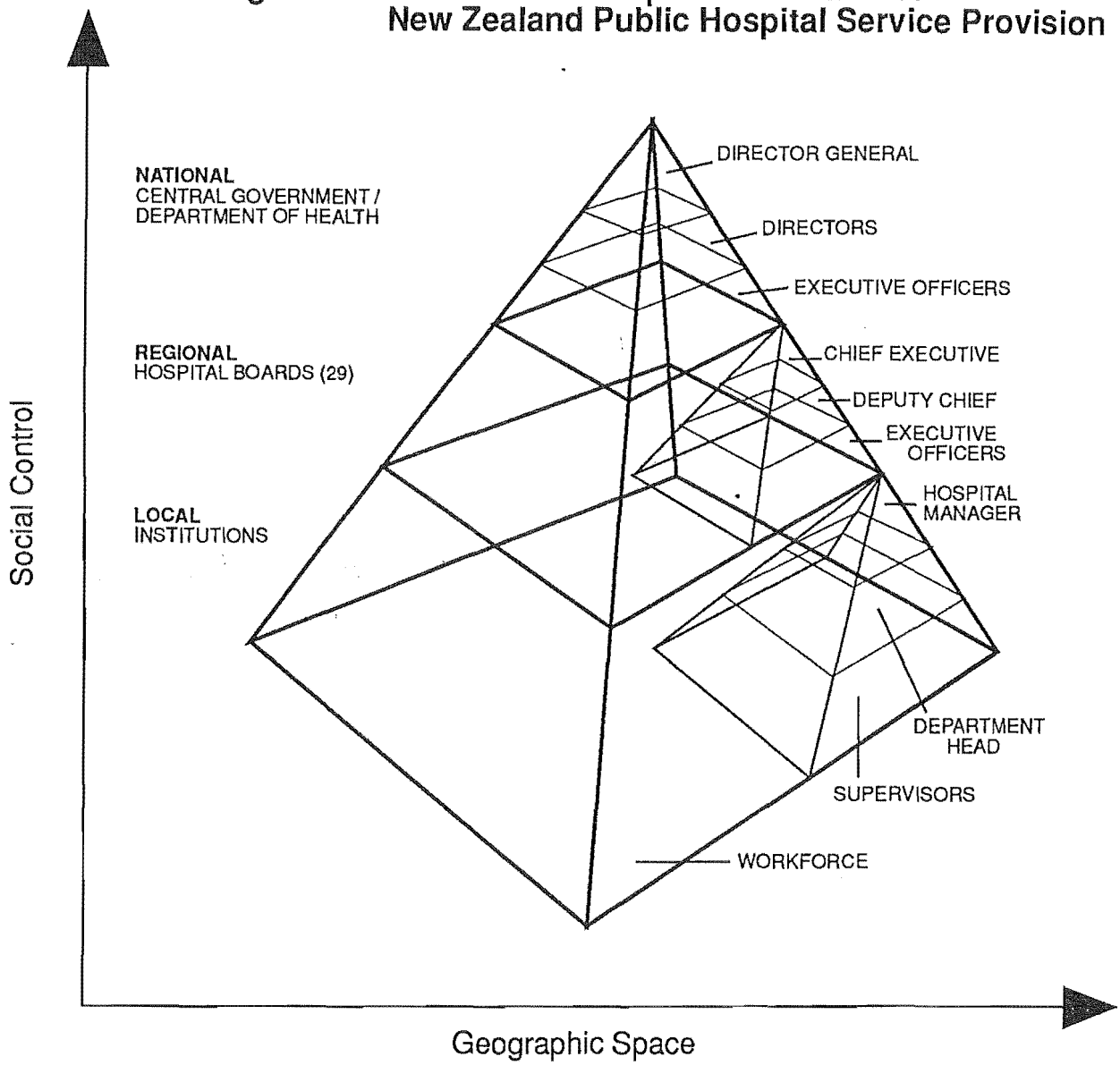
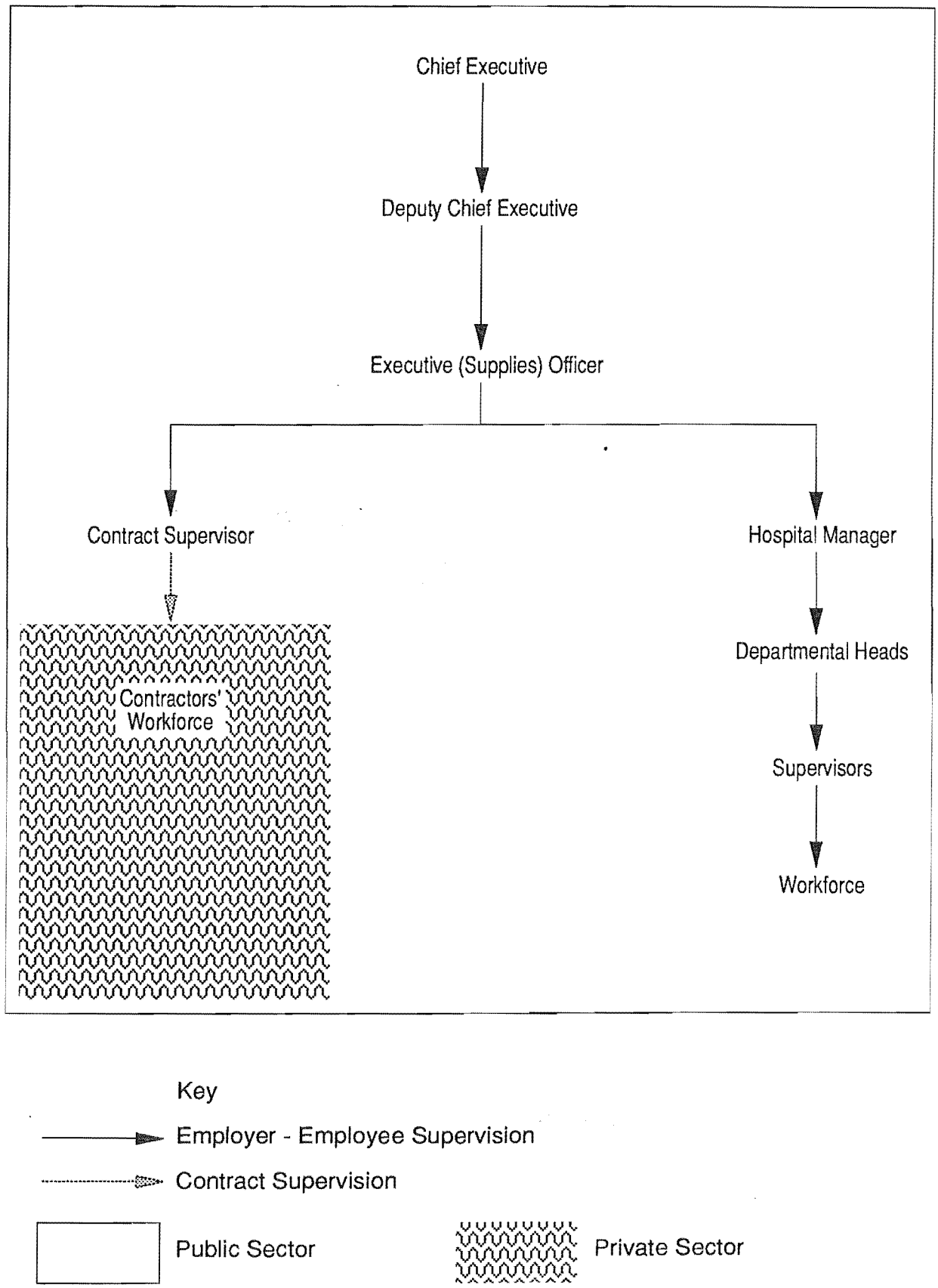


Figure 5.4 The Administration of Public Hospital Ancillary Services in New Zealand Hospital Boards: Lines of Communication



two specific examples: the Canterbury and the Ashburton Boards. Since these structures do not remain static over an extended period the year 1988 has been selected for examination.

5.5 The Provision of Ancillary Services in Canterbury and Ashburton Hospital Boards:

The Canterbury and Ashburton Hospital Boards, along with the South Canterbury Board were both amalgamated into the Canterbury Area Health Board in 1989. In the year before amalgamation each served populations of 355,300 and 24,700 and had 3,021 and 220 beds respectively (*Hospital Management Data* 1988). Within Canterbury is the third largest urban area in New Zealand whose population in the 1986 census was 299,373 while, for the same census year, Ashburton township was only 15,229. In 1988 the Canterbury Board operated 19 hospitals, nine of them within the bounds of the Christchurch urban area, while the Ashburton Board had just two hospitals both located within the township itself as shown on the maps in figure 5.5.

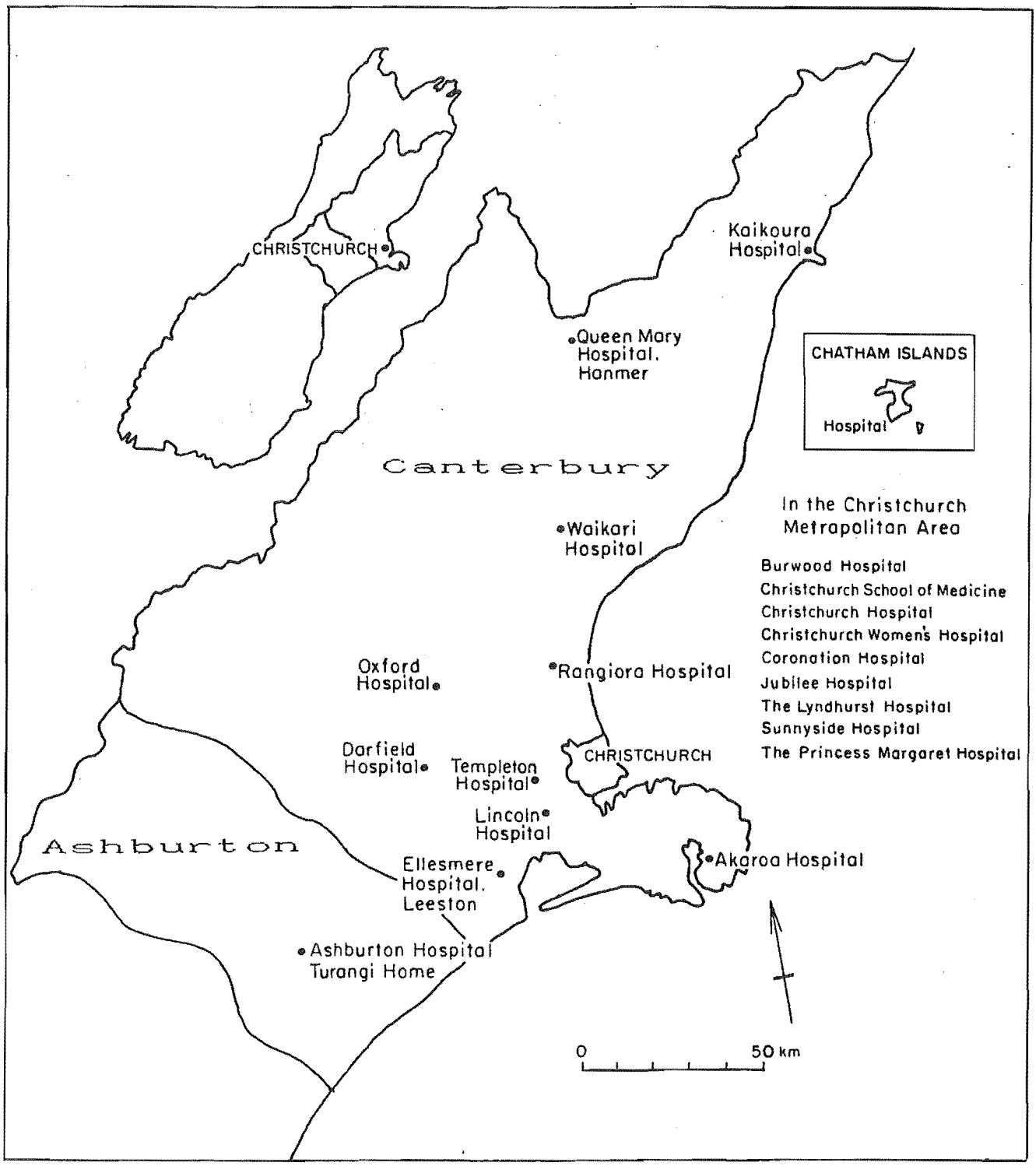
Apart from differences in gross population characteristics, the two spatially contiguous boards had quite different forms of ancillary service provision. Taking the Canterbury Board first, only domestic services were contracted out and then only at seven hospitals, five of which were in those of greater than 100 beds. All seven hospitals were in Christchurch and the other two hospitals in the urban area which had no contract provided services were both psychiatric institutions which have always provided their own services.

In the Ashburton Board, although much smaller than Canterbury, contracting out has been much more extensive and has applied to all ancillary services except the laundry requirements. This latter service is provided directly by the boards themselves in both cases. Prior to 1989 however the laundry service at Kaikoura Hospital, about 200km north of Christchurch in the Canterbury Board, was contracted out to a local firm. The major differences between the two board's hospitals in terms of size, functional classification and the extent of ancillary services contracted out are presented in figure 5.6. These differences in size and forms of service provision has meant that the bureaucratic structures for administration have varied considerably in both cases. Each will be considered in turn taking Canterbury first.

5.5.1 The Canterbury Hospital Board:

In Canterbury there has been a split between contract and board provision for ancillary services with a different administration in each case. For all the board's hospitals and institutions the overall

Figure 5.5 The Location of Public Hospitals in the Canterbury and Ashburton Hospital Boards



Source: adapted from the *Canterbury Hospital Board Annual Report*, 1988

Figure 5.6 Comparison of Contracting Out Ancillary Services in Canterbury and Ashburton Hospital Boards

Hospitals	Bed Numbers	Classification	Ancillary Services			
			Domestic	Orderly	Dietary	Laundry
CANTERBURY HOSPITAL BOARD						
Christchurch	488	General				
Princess Margaret	321	General				
Burwood	309	General				
Coronation	141	General				
Chch Women's	121	Maternity / Gyn				
Jubilee	78	Geriatric				
Lyndhurst	-	Day				
Sunnyside	681	Psychiatric				
Templeton	674	Psychiatric				
Queen Mary	117	Psychiatric				
Kaikoura	22	General				
Oxford	15	Geriatric				
Rangiora	14	Maternity				
Waikari	9	Maternity				
Darfield	8	Maternity				
Lincoln	7	Maternity				
Ellesmere	7	Maternity				
Akaroa	5	Maternity				
Chatham Islands	4	Maternity				
ASHBURTON HOSPITAL BOARD						
Ashburton	130	General				
Tuarangi Home	90	Geriatric				

Key:

Services provided by Contractors

Services provided by Hospital Boards

responsibility for the service provision, under either arrangement, has rested with the projects officer. Beneath this position have been the individual hospital managers and a contract supervisor. The former has had responsibility for the orderly services in their respective hospitals while the one contract supervisor has covered all hospitals that engaged contractors and was required to ensure on-going quality control.

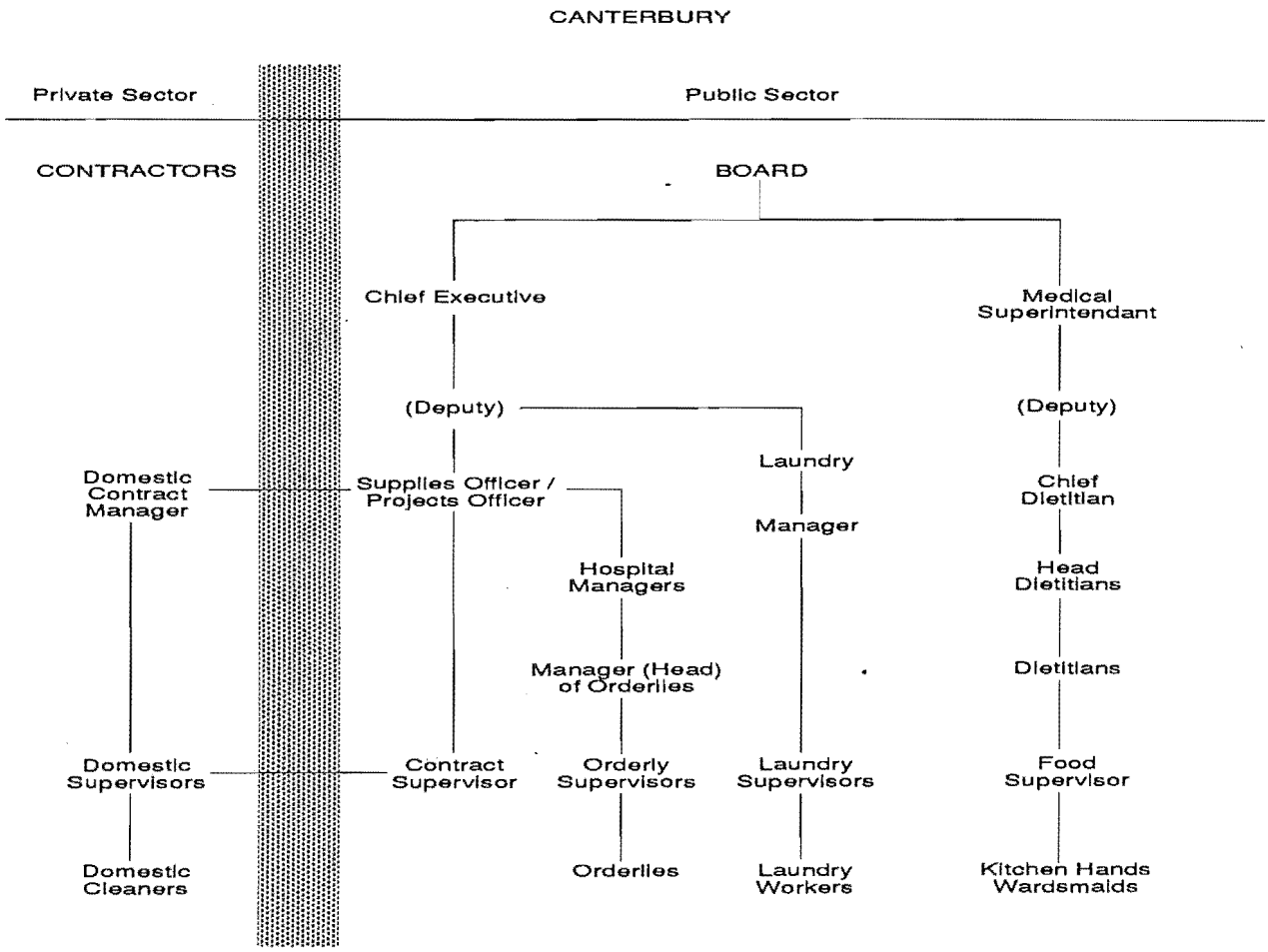
In respect of contract provided services the administrative tasks related to negotiating contracts, assessing tenders and communicating with contractors themselves has been the responsibility of the projects officer. For a detailed knowledge of the day to day running of the contract, particularly in regard to standards of service provision, the project officer has drawn on advice from the contract supervisor. When any policy decision over contractual arrangements was required, such as a change of contractors or a continuation with the incumbent contractor after competitive tendering, the matter then had to be referred to the deputy and then to the chief executive for approval before being presented to the elected members of the board's finance committee. This committee, which was one of five, would assess the proposal and, if approving of it, would forward it to the monthly meeting of all board members for final ratification. Only after this procedure could the proposal be adopted as policy. The line of communication therefore went from the contract supervisor at the workface to the projects officer and then successively to the deputy chief, the chief executive, board finance committee, and finally the full board.

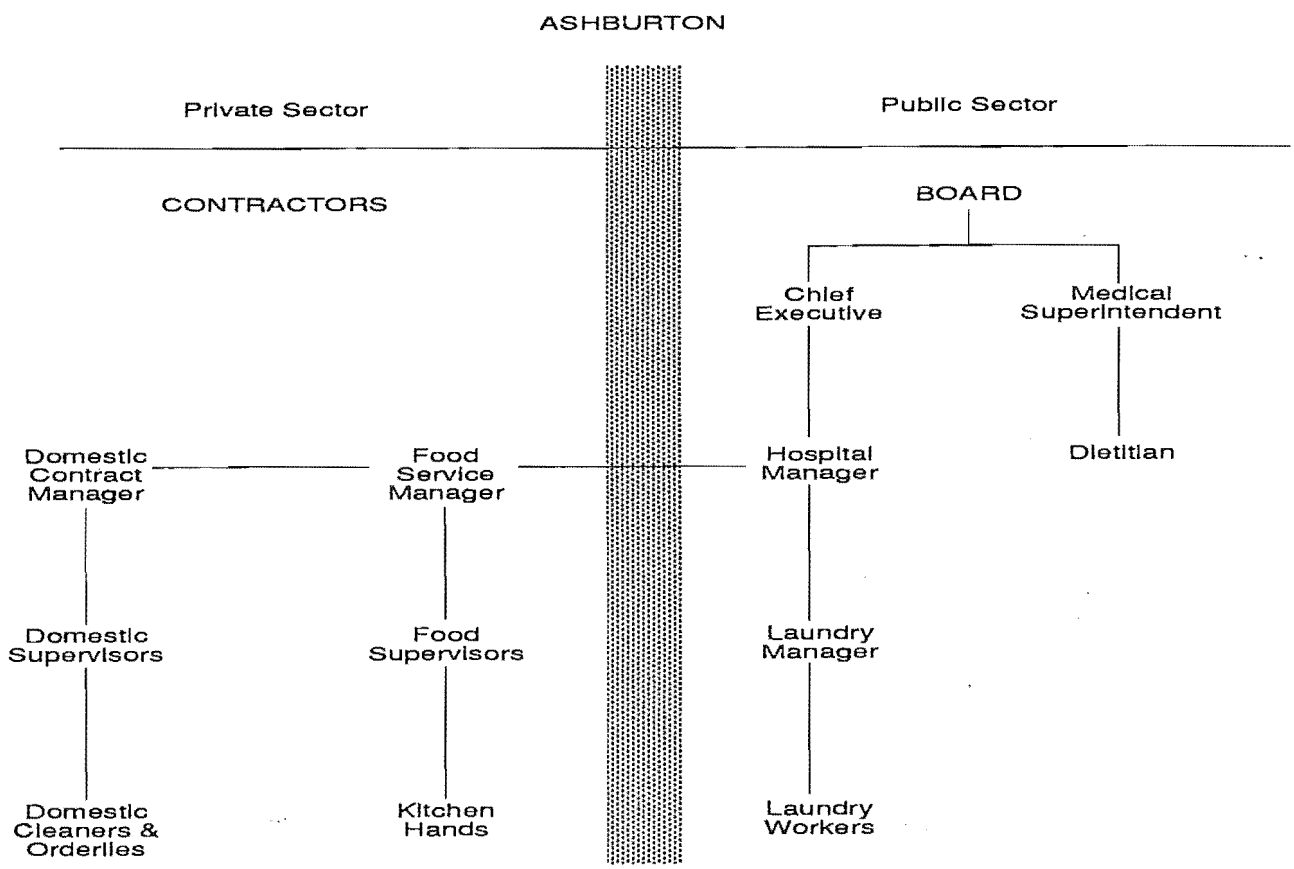
With board-provided ancillary services the administrative structure has varied somewhat with each individual service. In the case of orderlies the communication channel was from the work site supervisor to departmental head, to hospital manager, projects officer and then continued as with contract provided services. A similar gradation of managerial hierarchy occurred in the dietary section but under the ultimate direction of the medical superintendent. The administration of laundry services has been different if only because the service is centrally provided for all hospitals rather than individually (institutionally) provided for each one. A regional manager of linen services had the overall responsiblity in this area and the position was directly subordinated to the deputy chief executive. The hierarchical structure of all ancillary services' administration in Canterbury is illustrated in figure 5.7.

5.5.2 Ashburton Hospital Board:

In the case of Ashburton, there has been a far greater private sector

Figure 5.7 Administration of CANTERBURY and ASHBURTON Hospital Board's Ancillary Services and Private / Public Sector Interaction





presence in the provision of ancillary services. The task of contract supervision, rather than being a specialised function, has been part of the hospital manager's responsibility. The duties of this position have also included the overseeing of laundry services as well as other administrative tasks. There have been, in effect, two fewer tiers of administration than in Canterbury as there has been neither a projects officer or equivalent, nor a deputy chief executive. In Ashburton the line of administrative communication has been direct from the hospital manager, who covered both the board hospitals, to the chief executive.

Both supervision of standards and negotiations with the contractors, in either housekeeping or dietary services, were conducted between the hospital manager and the contractor's on-site supervisor or, if necessary, the branch manager. Even though the dietary services were contracted out, the board still employed a dietitian who had to ensure, from a clinical dietetic viewpoint, that the contractor provided a satisfactory service. All other aspects of quality control were under the supervision of the hospital manager. In contrast to Canterbury, however not only was day to day authority devolved to a lower level (ie hospital manager rather than executive officer), the quality control system operated was passive rather than active. It relied on departmental heads reporting shortcomings in service provision to the hospital manager. The controlling function then was only exercised as and when required instead of on a permanent basis as in Canterbury.

In matters relating to policy changes rather than day to day supervision, such as renegotiating with or changing contractors, the chief executive assumed the responsibility. There was however reliance on the information and advice supplied by the hospital manager. As with Canterbury all proposed changes in contracting out policy had to be submitted to the elected part of the board. This comprised only two committees, one for finance, the other for buildings and works with ancillary contracts being handled by the former. It was always the chief executive who made the final decision over which policy to recommend to the board's finance committee. So, for example, a proposal to change contractors would first have to be agreed upon by the chief executive following advice from the hospital manager. After this stage the chief executive then had to gain approval from the board in order to implement the proposal. In figure 5.7 above the comparative management structure with Canterbury is presented.

This brief study of these two boards' administrative structures has attempted to show that the physical size of the hospital board as an

institution can be an important factor in influencing the spatiality of service provision. The smaller the board, the more integrated is the central and local administration and fewer levels (tiers) of management are involved. By contracting out services there is also a tendency to reduce levels of management which in turn alters a board's administrative structure. But while the basic socio-spatial structure of public hospital administration has remained fairly constant over the years, the geographical pattern of contracting out ancillary services has been anything but constant. It is to detail the uneven development of contracting out these services across all New Zealand hospital boards that attention focuses upon in the next chapter.

Conclusion:

After establishing the rationale for undertaking an empirical study of public hospital services, this chapter has shown that the bureaucratic (appointed) and democratic (elected) structures for administering these services have existed at three principal spatial scales; the national, the regional and the local. The first is the central government's Department of Health, the second the 29 hospital boards and third the individual hospitals and institutions. The provision of ancillary services has been predominantly at the local institutional scale with the exception of laundry which is regionally provided. As the comparative case study has shown, contracting out can exhibit regional variations in both its spatial and sectoral extent. Certain ancillary services may be contracted out in one board and not in another, while the same service may be contracted out at a different number of institutions across any two boards.

Yet notwithstanding this spatial dissimilarity in contracting out policy, all boards and their constitutive institutions operate within the same national framework governed by the same legislature. The 1956 Hospitals Act and 1983 Area Health Boards Act, both of which have had major effects on hospital administration, have still engendered significant differences between boards in respect of their provision of ancillary services. Although just two specific examples of boards have been presented here similar observations could equally have been extended to cover all the other 27 hospital boards that existed until 1989. To this end the following chapters examine contracting out in a broader context both spatially and socially than the necessarily rather static account presented here.

Footnotes:

1 HMOs (Health Maintenance Organisations) were established in the 1960s in the USA and encouraged by the federal government as a way of reducing

health care costs. They are private organisations which charge a set annual fee to all their patients regardless of treatment required. The treatment is provided through the HMO contracting with which ever hospital or medical practitioner can provide the most economical service, with the emphasis being on minimising the duration of hospitalisation.

2 The publication has been discontinued since 1988. At present the collation of all data relating to public hospital services is under review. No other publication has yet superceded *Hospital Management Data*.

CHAPTER 6

The Geographical Basis of Contract Service Provision for Public Hospital Ancillary Services

This chapter has two main objectives. The first is to detail the overall historical development of contracting out public hospital ancillary services, giving specific attention to the geographical basis of the process. The second objective is to start analysing the particular spatial patterns observed in the first, part with a view to presenting explanations in terms of the theoretical frameworks established in chapters two and three. By developing further some of the material presented in the previous chapter, the analysis focuses on regional variations in the organisational characteristics of the different hospital boards and their respective ancillary services. Changes in the broader socio-economic and political environment in which hospital boards have had to operate and the possible affect on contracting out services are discussed in subsequent chapters.

The first four sections of this chapter outline, in sequential order, the development of contracting out ancillary services, changes towards more competitive tendering for contracts, the different scales of private capital involved and alterations in the observed geographical patterns over the last two decades. These four sections together provide the foundation upon which to procede with an analysis of the process of contracting out. A start in this direction is made in the subsequent three sections which examine the organisational differences between the services contracted out, the size of the institutions in which they are contracted out and finally some locational aspects of the institutions themselves.

6.1 An Overview of the Growth of Contract Service Provision

6.1.1 The Historical Origins of Contracting Out:

The historical origins of contracting out public hospital ancillary services in New Zealand extend back to the early 1940s when the process first developed in response to the critical labour shortage brought about by World War Two. The significance of national and regional labour shortages to the development of contracting out will be investigated thoroughly in the next chapter, but for the present purposes it may simply be noted that reference material detailing the geographical growth of the contracting out process over time is very sparse. Fortunately, field research has revealed a preserved copy of a letter from the Commercial Cleaners Company to the Secretary of the Wairarapa Hospital Board in September 1948 which has listed the public hospitals at which the company had contracts at the time. The hospitals concerned and their respective

localities are listed in figure 6.1. Their cartographic representation for the year 1950 is shown in figure 6.2 when it seems that only Wairau Hospital (Blenheim) in the Marlborough Hospital Board had commenced with contracting out in addition to those listed in 1948.

FIGURE 6.1: New Zealand Public Hospitals Contracting Out Domestic Services, September 1948.

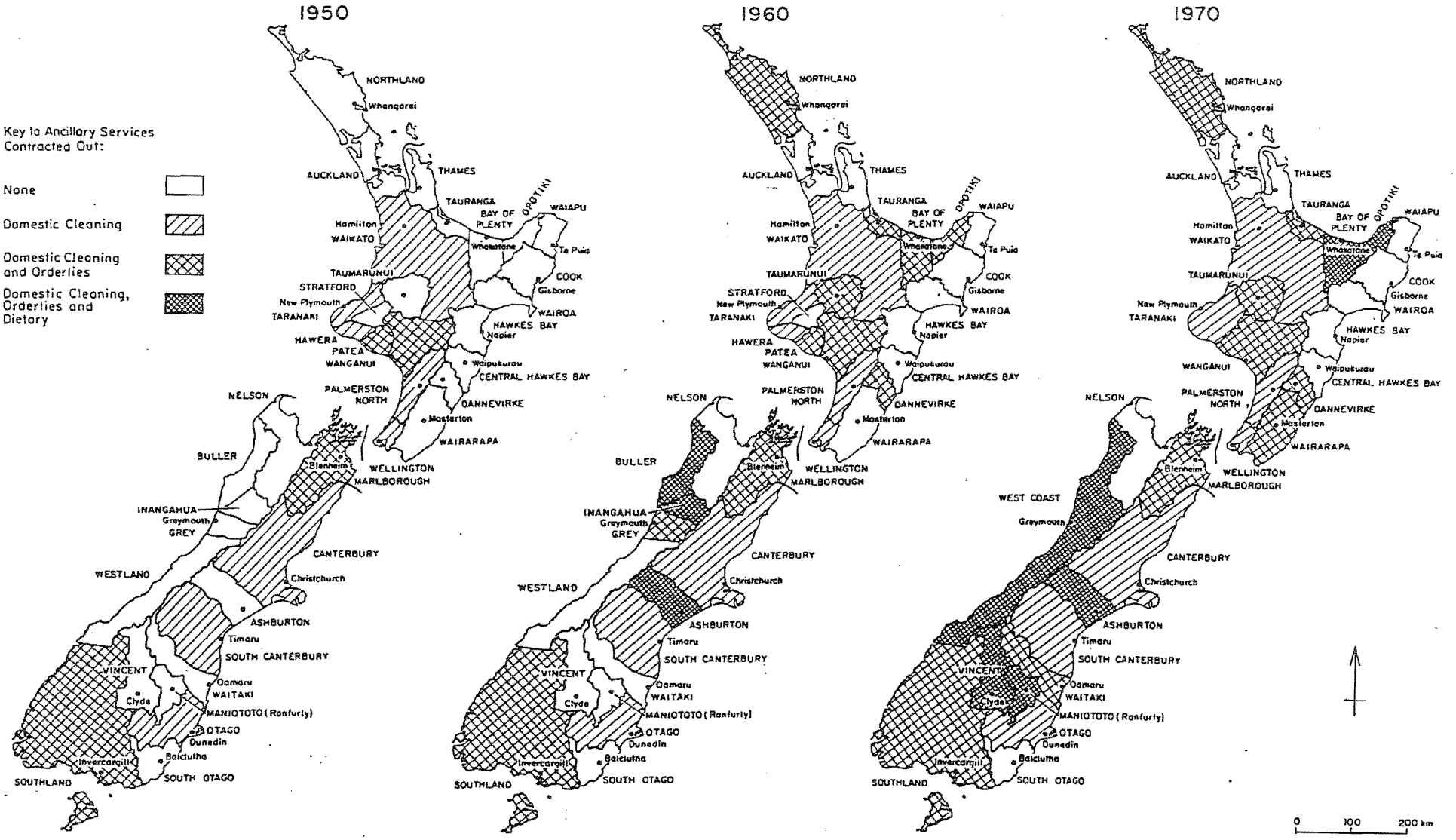
Hospital Board	Name of Hospital	Locality
Waikato	Waikato	Hamilton
Taranaki	New Plymouth	New Plymouth
Hawera	Hawera	Hawera
Wanganui	Wanganui	Wanganui
Palmerston North	Palmerston North	Palmerston North
*	Awapuni	*
Wellington	Wellington	Wellington
*	Hutt	*
*	Silverstream	*
North Canterbury	Christchurch	Christchurch
*	Burwood	*
*	Jubilee	*
*	Coronation	*
South Canterbury	Timaru	Timaru
*	Talbot	*
Otago	Dunedin	Dunedin
*	Queen Mary	*
Southland	Kew	Invercargill
*	Queen Victoria	*
*	Korne	*

Source: Letter from the Commercial Cleaners Company Ltd to Waipawa Hospital Board, 14th September 1948.

No record or indication was found of any other company holding contracts for domestic or orderly services in New Zealand public hospitals[1]. This could most likely be explained on the grounds that as this company was, and still is, by far the largest operator in the market for these services, no other would have had sufficient resources and expertise at its disposal to provide the services to the institutions concerned. It is believed therefore that this list gives a comprehensive statement of the extent of private contracting of these services in 1948.

The next list of public hospitals served by private contractors does not appear until 1962 where it is contained in a letter to the Wairarapa Hospital Board as part of a proposal to take over their cleaning and orderly services. As in 1948 the same company, Commercial Cleaners Ltd., was involved but in 1960 its name changed to that of Crothalls Hospital

FIGURE 6.2: Ancillary Services Contracted Out within New Zealand Hospital Boards, 1950-1970



Source; compiled from information supplied by New Zealand Hospital Boards

Services. By this stage it is possible that other contractors may have been involved at some hospitals but even from the incomplete records that exist on the subject all the available evidence indicates that those boards which had no Crothalls' contracts also had none with any other company.

The geographical extent of private contracting in 1960 (figure 6.2) has been estimated from the 1962 list. Regrettably both board and company records are too incomplete to detail the precise spatial pattern of contracting out for any particular year in the 1950s. Nevertheless the information that was available showed no extension of contracting out between 1960 and 1962 and therefore cartographic presentation can reliably be given for 1960. This provides a decade of comparison with 1950. One noteworthy feature from the maps is that as well as a spatial development in the process since 1950 there had also been a sectoral one, as by 1960 orderly services were also contracted out in several hospital boards.

After 1960, lists of contracts held by Crothalls Ltd. no longer present a comprehensive overview of the situation as other competing companies started to enter the market during the late 1960s, even if only briefly. The situation however can be clarified as there is a better supply of hospital board records than previously. These records comprised mainly the minutes of board meetings and correspondence between boards and contractors. The third map in figure 6.2 is constructed largely from these records and shows the contracting out situation in 1970. The geographical growth of this form of privatisation over its first 20 years is detailed in the three maps of figure 6.2 while table 6.1 identifies the particular time periods during which various boards started to contract out.

During the 1960s private sector contracts for dietary services were introduced, with the Vincent and Maniototo Boards being the first in New Zealand to adopt this form of provision. There was a slight expansion in contracting out activities into dietary services at the end of the 1960s, although it has not been possible to determine precisely the years in which this occurred. Ashburton, Bay of Plenty and West Coast were the Boards concerned, with the latter being formed from an amalgamation of four smaller Boards in 1970; Buller, Inangahua, Grey, and Westland.

Cartographic comparison of levels of contracting out between boards is unfortunately complicated by there being variations in the process within the boards themselves as was shown with Canterbury and Ashburton in the previous chapter. However the research undertaken points strongly to the largest general[2] hospital of each board being the first to contract out

TABLE 6.1: Time Periods in which Hospital Boards commenced Contracting Out

- 1950

Hospital Boards	Location of Board Office	Mean Population 31st March 1950	Total Beds 31st March 1950
Wellington	Wellington	220,330	2,030
North Canterbury	Christchurch	212,950	1,001
Waikato	Hamilton	156,470	934
Otago	Dunedin	110,460	598
Southland	Invercargill	78,110	575
Palmerston North	Palmerston North	72,180	528
Wanganui	Wanganui	55,140	416
South Canterbury	Timaru	46,870	378
Taranaki	New Plymouth	43,900	295
Hawera	Hawera	20,440	126
Marlborough	Blenheim	19,180	224
		1950 - 1960	
		31st March 1960	31st March 1960
Northland	Whangarei	88,690	623
Tauranga	Tauranga	39,230	260
Bay of Plenty	Whakatane	28,120	137
Ashburton	Ashburton	23,070	210
Grey	Greymouth	16,910	177
Taumarunui	Taumarunui	15,470	129
Dannevirke	Dannevirke	13,970	148
Buller	Westport	10,220	102
Opotiki	Opotiki	7,950	75
Patea	Patea	7,090	57
Inangahua	Reefton	3,330	59
		1960 - 1970	
		31st March 1970	31st March 1970
Wairarapa	Masterton	45,480	350
Waitaki	Oamaru	23,350	210
Vincent	Clyde	8,680	86
Maniototo	Ranfurly	2,810	62

Data Source: Department of Health Records and Hospital Board Records.

services. If this hospital did not contract out neither did any other. For cartographic representation, as in figure 6.2, the following distinguishing criteria has been adopted for a board to be shown as a contracting board. As a minimum, either all the cleaning services at the main general hospital are contracted out or there is a continuous expansion over time in the contract service towards total coverage of the hospital.

Following this second point it should be stressed that, in the larger hospitals at least, contracting out generally developed in a gradual manner rather than there being a sudden transference from board to private provision. Records indicate, but do not unequivocally confirm, that while contract cleaning first started in 1948 in the Southland, Wellington, and Otago Hospital Boards, it was not until the late 1960s that the main hospitals in these boards adopted full contracts. The case of the Auckland Hospital Board however is even more complex to determine.

Apart from the early brief period of contracting out referred to above, the Board seems to have maintained most of its domestic cleaning services in-house until 1981 when full contracts were let at Auckland Hospital. Existing records only extend back to 1972 and, according to the Auckland management, "*Prior to August 1981, the housekeeping services at Auckland Hospital were shared between Board staff (85%) and a commercial cleaning contractor (15%)*" (Management Report to Auckland Hospital Board, 30th November 1987). Just when this 15% contract commenced has not been possible to trace although it was certainly before 1972. Because there was no continuous growth in contracting out over the years prior to 1981, this Board has not then been shown on any of the maps as having contracted out services prior to 1981. Other boards seem to have had a less obscure history of contracting out as the policy has progressed fairly uniformly over time to the state of having their full service contracted out.

Throughout the 1950s and 1960s, contracting out expanded fairly uniformly. It initially centred on hospital boards covering major urban areas, with Auckland being the exception, and proceeded to develop in some of the more peripheral areas of New Zealand. Similarly, within many of the hospital boards, the contracting out process appears to have developed from the urban core out to the rural periphery as the largest general hospitals contracted out first, followed later by the smaller periheral ones. After the mid 1970s a more complex geographical pattern started to emerge and this is discussed in the next section.

6.1.2 Hospital Boards' Contracting Out Policies since 1970:

Changes by hospital boards to the contracting out of ancillary services from the mid 1970s onwards are illustrated cartographically in

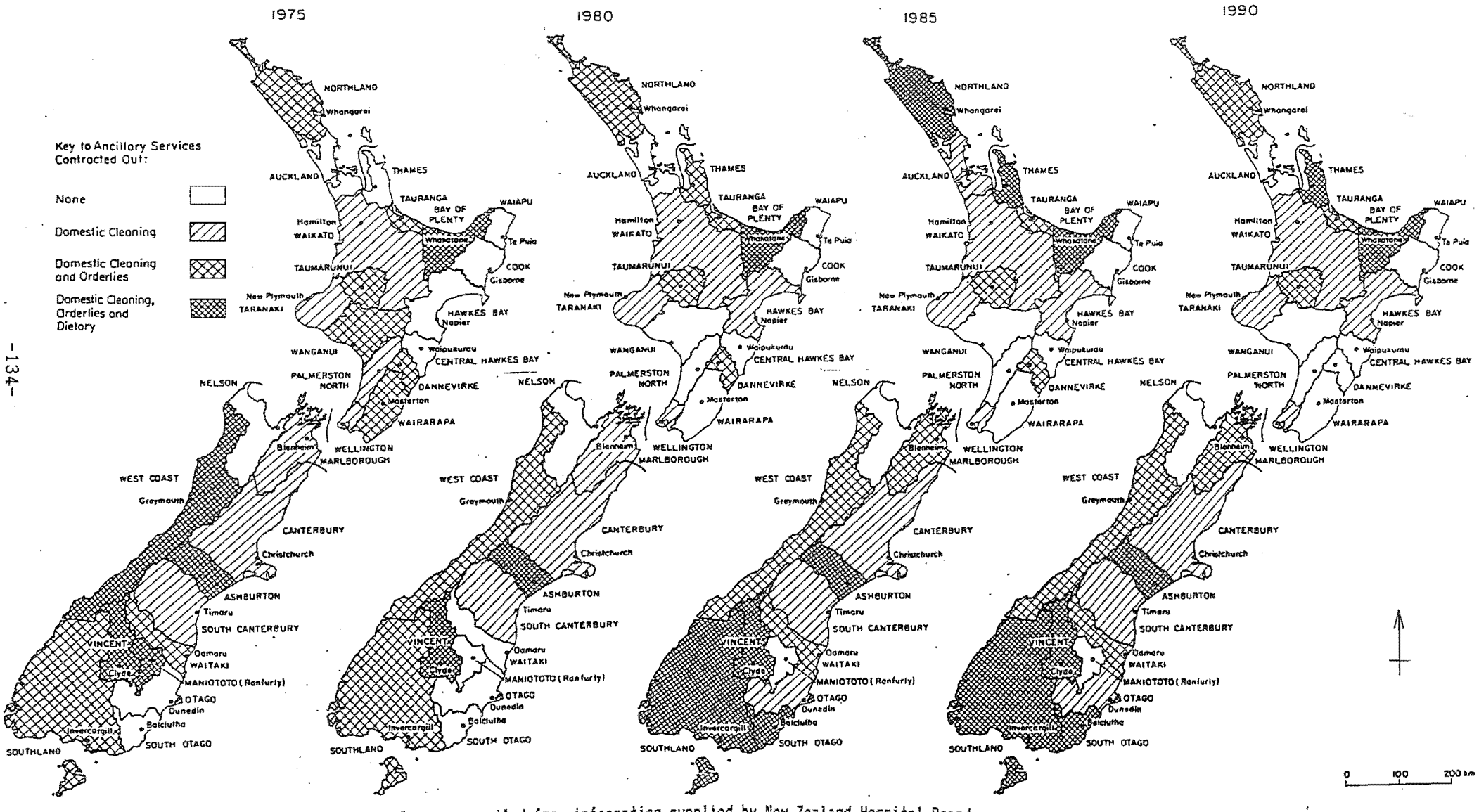
figure 6.3. The four maps are constructed in five year intervals from 1975 to 1990 and much of the information upon which they are compiled has been collated from enquiries to each individual hospital board concerning services provided by contractors. As the time period under consideration here only extends from around 1970 many of the difficulties encountered for detailing the period 1950-1970 do not arise. The hospital boards and their respective district boundaries shown in the map for 1990 had ceased to exist by mid 1989 with the change to area health boards (see chapter 5, figure 5.1). In spite of this there has still been a continuity in the spatial pattern of contracting out into 1990. So while administratively the final map is anachronistic it nonetheless gives an accurate presentation of the process.

Remaining hospital records indicate that the last board to contract out its ancillary services prior to 1979 was Waitaki in 1965. Between 1965 and 1979 the only further contracting out was a slight expansion in the existing activities of some hospital boards such as with the above detailed dietary services. At least two examples exist. In 1973 the Waikato Board, which had used contractors since the late 1940s at its major institution (Waikato Hospital, Hamilton), proceeded to contract out its domestic services at Taupo, Morrinsville and Te Awamutu Hospitals. Similarly, in 1973, the Wairarapa Board, extended the policy to cover the services at Pahiatua Hospital. Prior to this private contract provision had existed for domestic and orderly services since the early 1960s only at Masterton and Greytown Hospitals.

The following year (1974) saw the beginnings of the opposite process to contracting out in the New Zealand public hospitals. The Otago Board decided to revert to providing its own services while two years later in 1976, the Waitaki Board took over the employment of its own domestic and orderly staff although it still retained the incumbent contractor to manage the services. From that time on a 'management only' contract existed as distinct from a 'full' contract[3].

Some significant changes in contracting out policies took place between 1979 and 1983. In 1979 the Wanganui, Palmerston North and Wairarapa Boards, all spatially contiguous, ceased contracting out their services although the latter implemented a 'management only' contract for its dietary services. During the same year the Thames Hospital Board started contracting out for its domestic and orderly services for the first time. A year later Hawkes Bay and Maniototo each changed their contracting out policies but in opposing directions. The latter terminated the process just as the former commenced it. Around the same time the West Coast Board

FIGURE 6.3: Ancillary Services Contracted Out within New Zealand Hospital and Area Health Boards, 1975-90



Source; compiled from information supplied by New Zealand Hospital Boards

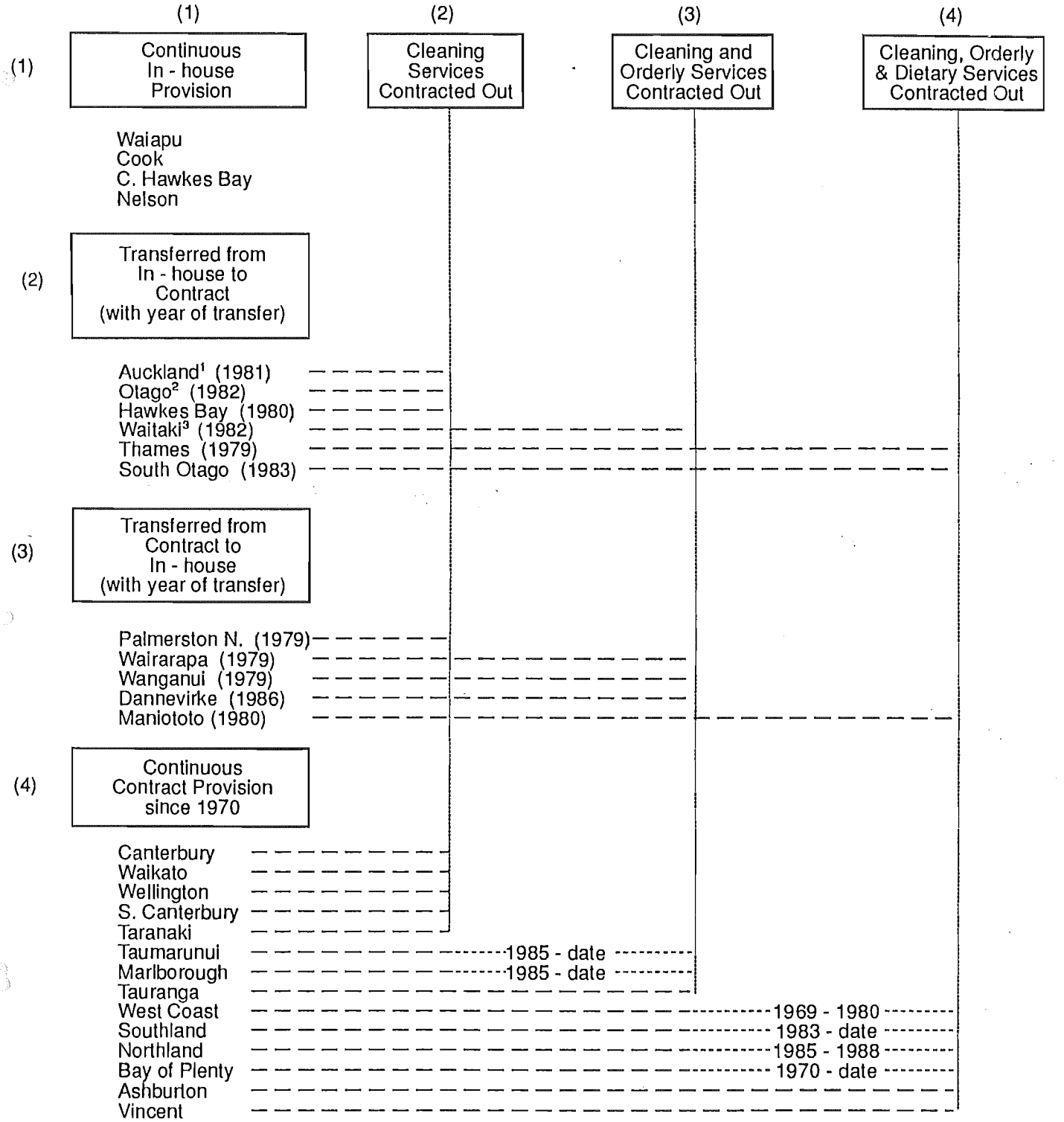
which had been using private contractors for its dietary services since the late 1960s reverted to in-house provision for this service. Going in the other direction, Auckland and Otago started contracting out their domestic services, or rather restarted in the latter case, in 1981 and 1982 respectively. Waitaki also restarted in 1982, after experiencing a management only contract since 1976, while in the following year South Otago contracted out all its ancillary services for the first time.

Further developments in the growth of contracting out since 1983 have been confined to boards which had already been contracting out at least some of their services. Dietary services were contracted out in Southland and Thames in that year, followed by Northland in 1985. During the time in which these developments occurred some other boards were reverting back to in-house provision. The West Coast Board progressively reduced the number of contracts at its various institutions throughout the 1980s until at the end of the decade there was contract provision only at the Board's one major hospital in Greymouth. In 1986 Dannevirke finished with all its contracts as did Auckland in 1988 and Northland also terminated its dietary contract in that same year.

In view of the numerous changes that have occurred, and the two opposing directions that they have taken, it has been exceedingly hard to present an analytical classification of contracting out policies between hospital boards since 1970. An attempt at classification is made in figure 6.4 where changes to contracting out are grouped into a sectoral and a policy dimension. In the former case, the process has been classified into four categories starting from there being no services at all under contract and extending progressively to all services. It is noteworthy that domestic cleaning invariably represents the first level of contracting out, followed by a combination of cleaning and orderly services and finally these two combined together with the dietary services. Interestingly no other variation on this arrangement has been found to exist.

Laundry services have only been contracted out to the private sector in very isolated instances and are not detailed on the maps. In the Canterbury Board the laundry at Kaikoura Hospital, about 200km north of Christchurch, was processed by a local private firm until mid 1989, after which time the Board itself took over the service. Based on the memories of long standing personnel, it is believed that during the 1960s, the laundry service for Buller Hospital (Westport) may have been contracted out. No documented confirmation of this has been found and certainly by

Figure 6.4 Classification of New Zealand Hospital Boards' Contracting Out Policies for Cleaning, Orderly and Dietary Services since 1970



1) Auckland had reverted to in house provision in all its institutions by June 1988.
2) Apart from at one small hospital, Otago had no contract provision for cleaning services, 1974 and 1982.
3) Waitaki had contract provision for cleaning and orderly services until 1976 and a 'management only" contract between then and 1982.

Source; compiled from information supplied by New Zealand Hospital Boards

the mid 1970s, and ever since, the service has been provided by the Board itself. Apart from this the Dannevirke, Marlborough, Maniototo, and Vincent Hospital Boards had their laundry processed by larger adjacent boards (Palmerston North, Nelson and Otago respectively) but there is no contracting out to the private sector.

Within the context of contracting out policy, a fourfold classification can also be determined. This again starts with those boards that have never, hitherto at least, contracted out any of their ancillary services; Waiapu, Cook, Central Hawkes Bay and Nelson. The next two categories comprise the boards which have pursued opposing policies. Since 1970 six different boards have either commenced or terminated the process with half of them having experimented with both contract (private) and board (public) provision during this time. The remaining 14 of the 29 hospital boards have continued throughout the two decades to maintain a consistent contracting out policy and changes have come in the form of alterations to the existing contractual arrangements rather than a complete change of policy.

The immediate task is to explain the uneven privatisation in terms of these sectoral and policy dimensions identified in figure 6.4. A temporal dimension must also be added to the debate by considering why these changes in contracting out policies took place during the time period under consideration, and why particularly so many between 1979 and 1983. Before proceeding further in this direction it is important to consider a further development in the process. During the 1970s, but particularly in the latter years of the decade, there was also a very important change in the method of contracting out. Where contracting out existed, or was resorted to, a process of competitive tendering often developed.

6.2 Competitive Tendering and Changed Forms of Contracting Out in the 1980s:

Prior to the 1970s, contracts for ancillary services had usually been renegotiated or "rolled over" periodically with the same contractor, generally Crothalls Ltd. (Commercial Cleaners Company). During the 1950s and 1960s contracts were usually drawn up on a cost plus basis using, what was generally termed, a standard labour schedule. Each hospital had a schedule of work to be done at a given frequency and a set number of hours were allocated to each job. The total hours represented the standard labour hours for which the boards paid the contractors a contract price. This form of contract seemed to work satisfactorily for several years. According to one hospital secretary in a letter of reference in early 1961 to a UK hospital authority on the issue of contracting out:

> The contract which my Board operates is based on standard work schedules costed at standard values which become the ceiling price. Any saving [by the contractor] on standard costs is returned to the Board and there is a measure of profit sharing. This form of contract has evolved through experiment over the years and is proving eminently satisfactory (Letter from Canterbury Hospital Board to Radcliffe Hospital, Oxford, 12th January 1961).

Under this arrangement all the costs involved were passed on to the board and the contractor was allowed a defined profit margin. There was not then any competitive pressure from the market for lower levels of profits and therefore reduced costs to the boards. Moreover, although there was 'a measure of profit sharing', boards eventually found that in practice they shared in very little of the contractor's profit. According to the Wairarapa Board:

> Crothall Industries Ltd. can also make additional profit out of employing less people than are shown on the schedule of duties. As there is no profit increase from increased production, the only way to increase the profit margin is to drop the staffing numbers while maintaining the same weekly charge to the Board (internal memorandum, 11th September 1978).

Many boards came to realise that this method of contracting out was not a worthwhile investment. The choice facing the boards was either to revert to labour directly employed in-house or to change the conditions under which the contracts were let. Where the former option was not resorted to, there was instead a substantial change in contracting out policy to one of competitive tendering.

When contracts were tendered out on a competitive basis, it was found that only the quantity and quality of services required needed to be specified. The amount of capital, labour and profit margin the contractor requires is then a matter of indifference to the hospital board and hence the cost plus element is eliminated. In the words of one hospital authority:

> With the competitive system, it should follow that all factors are considered [by the contractor] before a quote is made. Therefore, the method each firm uses to arrive at a figure is a matter for their concern and is of no relevance to the Board. Because of this, the only information needed relates to labour and materials' costs, plus the pricing structure, so that these can be used as a basis for comparison for tender evaluation and when requests for price increases are received (Hospital Board internal communication; 1981).

The rationale behind this policy innovation was that contractors would be obliged to minimise all expenditure in order to remain competitive, and the economies gained thereby would be passed on to the hospital boards in terms of lower contract prices.

In the cases where contracting out ceased altogether, this invariably followed a process of tendering out for contracts, whereupon it was found that the hospital board itself could provide the service itself more economically than could any outside contractor. Under these circumstances, competitive tendering did not lead to, or sustain, contracting out. Only very rarely in New Zealand has the process of in-house tendering been attempted, whereby tenders are submitted from individual institutional managers to the hospital board along with those of outside contractors. Instead the procedure seems to have been that on receiving outside tenders they have been assessed in comparison to what the board's management have estimated they could provide the service for themselves. Their recommendation as to the most suitable form of provision has then been placed before the elected board members for approval.

The change from contracting out by negotiation to that of competitive tendering has still not been universal across all boards. Some have been regularly tendering out their contracts for ancillary services since the 1960s while others still find that the optimal arrangement is a negotiated contract using a standard labour schedule. As many, if not most, boards have periodically changed between having tendered and negotiated contracts, it has not been possible to make a definitive spatial or temporal distinction between the two categorises.

Instead of, and sometimes as well as, these changes in the form of contracting out, most boards have been able to make financial savings by insisting on the contractors reducing their prices. This has been achieved primarily through stipulating reduced service requirements in the tender documents provided by boards to incumbent and prospective contractors.

As far back as the late 1960s the the Department of Health was urging boards to adopt a policy of competitive tendering by claiming that, "*.... it has become apparent that with the number of firms now tendering for cleaning contracts, tender prices have become very competitive*" (Health Department Circular, 7th November 1969). From the late 1970s onwards, the government made further efforts to persuade boards to adopt a competitive strategy in service provision. Circular letters from the Department of Health were issued to each hospital board chief executive advocating this policy. One such circular issued in 1981 stated that:

> It has come to the department's attention that not all boards for which cleaning is done under contract are calling competitive tenders for the work. The purpose of this circular letter, therefore, is to advise that no cleaning contract should be entered into without the prior calling and consideration of

competitive tenders (Health Department Circular, 6th April 1981). A further circular in 1983 was even more emphatic saying that, "*Indeed regarding the use of taxpayers money, it would be inviting criticism from suppliers and contractors if tenders were not called on the widest basis feasible*" (Health Department Circular, 21st October 1983).

During the 1970s, but particularly the 1980s, the provision of public hospital ancillary services was not simply an issue of whether this was to be in-house or by private contract. Even more important has been how the latter form of provision was to be implemented; whether by negotiation with a single contractor or through a competitive tender. An important factor in predisposing a hospital board towards contracting out a service has been the supply of private contractors since this critically affects the viability of competitive tendering. It is to a discussion of the growth of contractors that attention turns in the next section.

Summary:

The development of contracting out public hospital ancillary services can be grouped into four main time periods. Prior to around 1970 the process developed fairly progressively starting with the boards covering major urban centres. By comparison the 1970s marked a period of relative stagnation but at the end of the decade and until the mid 1980s, the process developed in three different directions. First, some boards terminated their contracts and reverted to providing their own services. Second, a few other boards, which had hitherto provided their own services, adopted the contract option. Finally in many boards, where contracting out either already existed or had just been adopted, the form of the process changed from being one of periodic negotiation with the incumbent contractor to that of competitive tendering. The fourth time period lasted from around the mid 1980s to date and has been marked again by stagnation and even a slight decline in contract provision.

Viewed sectorally the process first commenced with domestic cleaning services and then expanded progressively into the orderly and dietary sectors. Throughout the entire history of contracting out, cleaning has had the widest geographical extent of privatisation followed by orderlies and then dietary services. With only a very few exceptions, laundry services have not been contracted out at all in New Zealand public hospitals.

6.4 The Market for Contract Service Provision:

The operations of the contract cleaning industry in New Zealand have been detailed by Brosnan and Wilkinson (1989) and therefore only a brief account will be provided here with specific reference to the provision of

hospital ancillary services. The virtual monopoly position of Crothalls changed in the 1970s when a long established Wellington based firm called the Vacuum Cleaning Company acquired contracts for domestic services at the Waikato, Palmerston North, Wellington, West Coast, South Canterbury and Otago Boards. During the decade these two companies had a virtual duopoly in the market. Although other companies existed, their market share for public hospital services appears to have been minimal. Even compared to Crothalls, which by the 1970s had become a multinational company, although still New Zealand based, Vacuum seems to have had only a very small share of the market at any one time.

To the extent that remaining records reveal, the only other companies to hold contracts in New Zealand public hospitals in the 1970s were two Auckland firms each of which had various branches throughout the country; Lloyds Cleaning Services and United Cleaning Services. The former held contracts with the Taranaki Board from 1975 to 1982, Palmerston North from 1970 to 1974 and Bay of Plenty until 1976 although in this latter case it has not been possible to ascertain the year of commencement. United held the contract for the very small part of Auckland Hospital that was cleaned under contract upto 1978 although again time of commencement is unknown.

Both Lloyd and Vacuum were taken over by Crothalls, in 1982 and 1984 respectively, and while United still exists to date it has not provided any hospital services since 1978. The 1980s saw more companies gaining hospital contracts although Crothalls still dominated the market through its acquisition of competitors and expansion of activities beyond its original base in contract cleaning. In 1977 a holding company, Command Services Corporation Ltd., was formed (in New Zealand) to take all the Crothall companies under its umbrella, while Brosnan and Wilkinson (1989, 84) observe that since then the company has expanded into such activities as:

> building maintenance (Crothall Property Services), private hospital management (Comprehensive Australasian Retirement Enterprises, Health Care Management Consultants), security (Securitas), alarm systems (Monitor Controls) communication services (Seekers), catering and vending (Huntsbury Food Services, Advanced Food Systems and Synergetic systems).

The founding in 1979 of a subsidiary company, called Advanced Food Services, led to specialisation in the provision of food services for hospitals and other public and private institutions.

During the same year however an Australian based firm called Berkeleys entered New Zealand and over the following years successfully competed with Crothalls to gain contracts with the Northland, Taranaki,

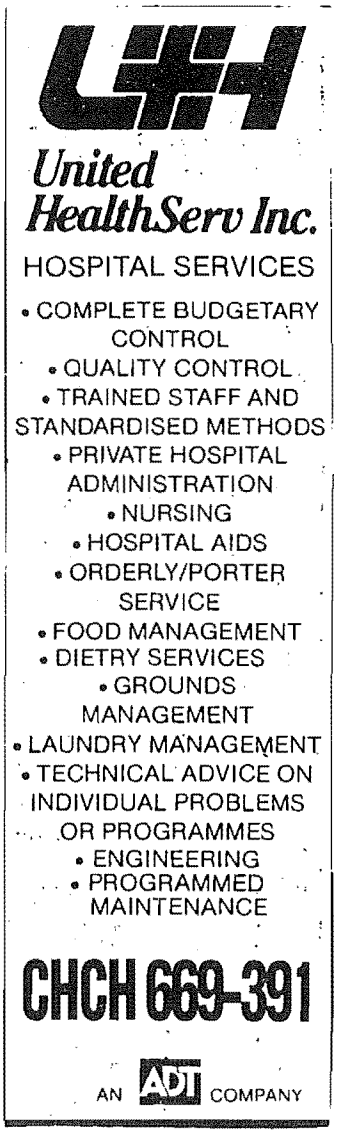
West Coast, Canterbury, Waitaki and Southland Hospital Boards. Small scale (ie local) capital also existed. A Wellington based firm called Newco acquired the domestic and orderly contract at Grey Hospital in the West Coast Board from 1980 to 1983 at which time this company was also taken over by Crothalls. After the existence of another virtual duopoly, this time between Crothalls and Berkeleys lasting from around 1984 to 1989, the latter became merged with the former and a new company was formed as a result of some major corporate 'restructuring'.

A holding company called Command Services was established in 1977 to take all the Crothalls companies under its control. In 1980 Command Services, was acquired by UK based Pritchard Service Company which itself merged with the Hawley Group in 1986. According to company literature, this made Command part of a company with a turnover in 1986 of approximately £1,000m sterling and over 100,000 staff working from 500 service centres, principally in the UK, United States and Australasia (written communication to Minister of Health, 11th November 1986). More recently still Hawleys acquired, and changed their name to an American company called ADT[4], which also owned Berkeleys. The New Zealand branch of ADT, formerly Crothalls, became ADT Services (New Zealand) in 1988 and restructured into two companies, Crothall Property Maintenance and United Health Serv (Brosnan and Wilkinson 1989, 84). So all prexisting public hospital contracts under either Crothalls or Berkeleys became provided under the name of United Health Serv. An idea of the activities of these two related companies can be gained by examining the extensive list of services they advertise in the telephone directory (figure 6.5).

During 1988 a Swedish based multinational called Electrolux finally gained contracts in the Taranaki and Canterbury Boards after several years of unsuccessful tendering for hospital services throughout New Zealand. Another competitor to emerge in this field in 1988 was a former Government Department known as the Internal Affairs Service Division which, for many years, had provided cleaning and maintenance services to government buildings such as Parliament House, Treasury and the Justice Department. Moves by the Government to corporatise and commercialise the state sector in 1987 resulted in the Service Division having to operate as a private company although, at the time of writing, the precise legal status of the enterprise is still uncertain. Nevertheless since April 1988 the company has been able to tender for contracts in both the public and private sector and in that same year it started to provide some of the domestic services for the Canterbury and Otago Boards.

The contract provision of hospital services has always been divided

FIGURE 6.5: Services Provided by ADT (New Zealand)



Source: Christchurch Telephone Directory, 1989.

very unequally between a variety of multinational, national and locally based companies. At present ADT (United Health Serv) and Electrolux are by far the largest companies although the former has the vast majority of public hospital contracts. At a national level, there is the Internal Affairs Hospital Service Division with numerous branches throughout New Zealand while there also exist three locally based, and individually or family owned, companies with public hospital contracts. Independent Cleaning Services of Dunedin, established in 1988 by two former Crothalls employees, took over all the domestic and orderly services from Crothalls in the Ashburton Board in that year. The previous year another recently formed company called Avalon gained all Crothalls contracts in the Wellington Board's hospitals while in the early 1980s a small, but long established, Christchurch firm called the Vacuum and Blue Ladder Company acquired a cleaning contract, again from Crothalls, with the Canterbury Board.

In summary the development of the market for hospital contracts has been one of domination by a steadily expanding company but with periodic entry by much smaller enterprises. Many of these new entrants have either lost their contracts or been taken over by the dominant company but, as just seen, in the last few years the wheel has been reinvented with new competitors coming into the market. In the words of Brosnan and Wilkinson (1989, 84):

> Despite its near monopolisation, the industry remains fiercely competitive. What is more, the low level of capital required for entry permits a substantial number of small, locally based firms on the periphery of the industry [which] can compete successfully with the major companies.

This process of increasing size of enterprise might seem to parallel the growth of private hospital care as outlined in the previous chapter. There is, however, an important difference between the two. Whereas in the case of private hospitals the increasing size of capital investment could be largely attributed to the growing technological complexity of the industry, the same argument cannot hold for such a labour intensive industry as contract cleaning. In this latter case the expansion of the industry has come primarily through service diversification so that large contract cleaning enterprises achieve scale economies through being engaged in far more acivities than just cleaning as figure 6.5 demonstrates. At the other end of the size scale however are the very small enterprises whose field of operation is confined to cleaning only in a similar way that most small private hospitals are increasingly restricted to geriatric and hospice care.

6.5 The Changing Geography of Contracting Out since 1970:

An examination of the maps in figure 6.3 readily reveals that although the spatial pattern of contracting out has been uneven across the years, the unevenness itself has changed considerably especially since the early 1970s. In the southern part of the North Island, there are five spatially contiguous boards - Wanganui, Palmerston North, Wairarapa, Dannevirke and Central Hawkes Bay - where there has been a progressive decrease in the extent of the process. By contrast, the far south of the South Island has seen the opposite occur with contracting out expanding its base in Otago, South Otago and Southland.

At the other end of the country, in the Northland, Auckland and Thames Boards, the process grew until 1985 but has since reduced in scale. The central areas of both Island seem to have experienced a slightly more stable pattern of contracting out over the time period under consideration here. To provide a complete contrast with these changes there are two regions which have always remained free of contractors. These are the East Cape area of the North Island, which is covered by the Waiapu and Cook Hospital Boards, and the Nelson Board district.

Possibly the most striking feature of the pattern of contracting out seen here is that within the boards covering New Zealand's major urban areas of Auckland, Hamilton (Waikato), Palmerston North, Wellington, Christchurch (Canterbury) and Dunedin (Otago)[5] there has been little contracting out and in some of them, at certain times, none at all. On the other hand, in the boards covering the smaller towns in areas peripheral to the main centres contracting out appears to have taken place either very extensively, insofar as at least two ancillary services are involved, or else there is no contracting out at all. Significantly, the boards in the former case are much larger institutions than in the latter case.

This apparent tendency to greater contracting out in smaller boards holds not only when size is measured in terms of board district and main city population for each of the census years 1976, 1981 and 1986 (table 6.2) but, more directly, when measured by the total bed numbers each board provides. With the exception of Nelson prior to 1986, a figure of 1,000 beds divides the hospital boards' contracting out policies into two. In all boards with more than 1,000 beds, contracting out has been, at most, confined to domestic services whereas below this any amount of ancillary services may be provided under contract.

As already pointed out there has also been a distinct geographical uneveness to contracting out within many hospital boards. Where boards

TABLE 6.2: THE SIZE OF NEW ZEALAND HOSPITAL BOARDS 1976-1986

BOARDS	MAIN CITY/ SETTLEMENT	1976 BED NUMBERS	1976 BOARD POPULATION	1976 MAIN CITY/ POPULATION	1981 BED NUMBERS	1981 BOARD POPULATION	1981 MAIN CITY/ POPULATION	1986 BED NUMBERS	1986 BOARD POPULATION	1986 MAIN CITY/ POPULATION
Auckland	Auckland	5309	796506	742786	4975	829465	769558	4475	889167	820754
Wellington	Wellington	3003	344338	327414	2644	338912	321004	2606	345620	325697
Canterbury	Christchurch	3131	344017	295296	3175	341518	289959	3130	353335	299373
Otago	Dunedin	2052	129187	113222	1752	122741	107445	1369	121843	106864
Waikato	Hamilton	2859	320411	94777	2817	326794	97907	2715	338524	101814
Palmerston N.	Palmerston N.	1674	125893	53873	1661	129384	66691	1475	133990	67405
Tauranga	Tauranga	411	66387	48153	417	75183	53097	414	85436	59435
Hawkes Bay	Hastings Napier	859	121508	50814 50164	782	125001	52563 51330	789	127644	54909 52151
Southland	Invercargill	772	116568	53762	743	117099	53868	705	116449	52807
Taranaki	New Plymouth	685	99312	43914	698	98500	44095	673	103107	47384
Nelson	Nelson	1161	64352	42433	1108	66313	43121	984	69777	44593
Northland	Whangarei	789	106743	39069	840	114349	40212	807	127616	44043
Wanganui	Wanganui	875	75714	39679	861	74295	39595	789	74232	40758
Cook	Gisborne	369	41136	31790	347	41428	32062	316	41325	32238
S. Canterbury	Timaru	485	62027	29958	503	59907	29225	492	56494	28621
Marlborough	Blenheim	290	31649	21481	303	34033	22104	234	34855	22681
Wairarapa	Masterton	337	46726	21001	329	45353	20422	304	44298	20145
Bay of Plenty	Whakatane	281	44467	14282	261	46547	15159	257	47616	15954
Ashburton	Ashburton	285	25316	15357	284	24925	15303	228	24855	15227
Waitaki	Oamaru	200	22576	15095	206	21782	14664	186	21514	14247
West Coast	Greymouth	852	34818	11811	851	34202	11604	673	34983	11261
Thames	Thames	332	33619	6769	309	35513	6456	291	39741	6480
Taumarunui	Taumarunui	151	12454	6479	156	12522	6541	123	12440	6387
Dannevirke	Dannevirke	153	12317	5638	149	12063	5694	137	13055	5873
C. Hawkes Bay	Waipukurau	197	13195	3632	195	12993	3648	174	13176	4322
S. Otago	Balclutha	214	17159	4740	181	16641	4515	141	15613	4227
Vincent	Alexandra Cromwell	79	9483	4137 1202	79	11005	4348 2364	79	13370	4842 3536
Maniototo	Ranfurly	33	2547	939	46	2582	994	46	2381	961
Waiapu	Te Puia	44	4606	312	44	4687	242	44	4628	225

Data Source: Census 1976, 1981 and 1986 and *Hospital Management Data*, various years.

have contracted out services, the larger urban based hospitals have, without exception, been the first to be affected. Some boards such as Northland, Ashburton and Vincent have contracted out services at all their hospitals whereas most others have retained in-house provision at the very small places many of which are rurally located. In only very few cases have hospitals with less than 50 beds had any of their ancillary services contracted out regardless of which board district they are located in. Institutional size appears therefore to have an important mediating role in determining the spatiality of privatisation both within as well as between hospital boards.

Whether the geography of contracting out is analysed at either the local (hospital) level or the regional (administrative) level, a further factor to be considered is the sectoral variation in the process. Examination of the maps in figures 6.2 and 6.3 reveals that domestic cleaning has always had the greatest spatial extent of contracting out. This is followed sequentially by orderlies, dietary and laundry services, the latter of which has not been contracted out anywhere except under the special circumstances already outlined. Uneven development of contracting out could be expected to occur in this context even if all the institutions concerned are of identical size and organisational structure.

6.6 Organisational Characteristics of Public Hospital Ancillary Services:

In the next two sections it is intended to see why there has been an empirically observable sectoral decrease in contracting out. The issue is examined in respect of relative levels of technology used in the different services and their different forms of administrative structure.

6.6.1 Levels of Technology and Labour Intensity:

On the basis of degrees of labour intensity and the capital equipment involved, a distinction can readily be drawn between domestic and orderly services on the one hand and dietary and laundry services on the other. The former two services, but particularly the latter of them, are characterised by the very low level of capital equipment required for their operation. An immediate consequence of this is that entry into the market is very easy for potential private sector contractors as Brosnan and Wilkinson (1989, 84) have noted. Compared to the other services considered here the market for contract cleaning in New Zealand has many operators and is highly competitive although meaningful comparative data is not available. Some contract cleaning companies have no office premises and are not even registered in the telephone directory, making quantification very difficult.

Although some technological and labour saving advances have been made

since World War Two in cleaning materials and equipment available, domestic cleaning is still a heavily labour intensive activity. Taking the most recent cost schedules submitted by contractors to hospital boards as a guide, at least 90 per cent of total contract costs are comprised of labour costs. Table 6.3 presents an illustrative example of this and shows how contractors' costs are calculated. As no separate contracts exist for orderly services it is not possible to give a figure for this service but there is certainly even less capital equipment used in this activity.

This provides a marked contrast to dietary and laundry services which both involve large investments in plant and equipment. But it is not only the size of the investment that is so important. These services have a vital strategic importance to the day to day functioning of a hospital. Most hospitals can function for some time without the labour of cleaners and, to a certain extent, without orderlies but in the case of dietary and laundry a continuous supply of these services must always be maintained for a hospital to function.

Whenever dietary services have been contracted out, the form of contract adopted is a labour and management only, or sometimes, a labour only one, but either way the capital equipment remains the property of the hospital board. In no case, to date at least, has any hospital board contracted out its dietary service to the extent that its own kitchens and catering equipment have subsequently become defunct. It may be argued therefore that, as regards maintaining vital service provision, there is a greater risk factor involved in contracting out dietary and laundry services compared to the other two.

In respect of laundry services, enquiries to individual boards have revealed that the principal reason for not contracting out is that no private sector operator is sufficiently resourced to process the quantities of laundry that hospitals generate. Whether this really is the case may be debateable but it still does not explain why a labour only contract could not be entered into with a contractor using the hospital board's existing plant and equipment as with dietary services. From discussions with the management of United Health Serv (formerly Crothalls) there seems to be a reluctance to enter into such an arrangement. A full contract is preferred in which the contractor would also own or lease the plant in addition to employing the labour. A lack of interest from private capital may be the best possible explanation that can be offered for the absence of contract laundry provision.

6.6.2 Professionalism and the Administration of Ancillary Services:

Of the four services under consideration, dietary is the only one in

TABLE 6.3: Example of Domestic Cleaning Contract Submitted to a Hospital Board in 1988[1]

Labour Costs	Wages		14,547.52	
	Holiday Pay	11.7%	1,702.06	
			16,249.58	
	ACC	2.25%	365.62	
	Public Risk	0.225%	36.56	
TOTAL LABOUR COSTS				$16,651.76 pw
Indirect Costs	Materials		249.72	
	Staff Travel		26.84	
	Plant Depreciation		149.83	
	R & M[2]		83.24	
	Vehicle Costs		91.56	
TOTAL INDIRECT COSTS			601.19	
TOTAL DIRECT & INDIRECT COSTS				$17,252.95 pw
	Overheads & Profits			993.42
		TOTAL COST		$18,246.37 pw
		TOTAL COST P.A		$948,811.24
		+ GST		94,881.12
		TOTAL PRICE		$1,043,692.36 pa

All labour based on the N.Z. Hospital & Domestic Workers Award 6/1/88

1 The names of both the contracting firm and the hospital board is this example have been withheld to preserve confidentiality.

2 Repair and Maintenance

uce: hospital board records

which state regulated, professional qualifications are attainable and indeed necessary. The professionalism, and hence formally recognised expertise, of dietitians has provided them with a much more powerful position in the board management structure than that possessed by either the head of the domestic or the orderly services. As was seen in chapter five the head dietitian has direct access to senior board management in the form of the medical superintendent whereas the other two service heads have had to operate through the manager of the respective institution (hospital) concerned rather than directly to regional (central) board management.

Although not by necessity professionally qualified, the laundry manager, like the chief dietitian, also has direct access to senior management usually in the form of the board's deputy chief executive. Unlike either domestic or orderly services, both laundry and dietary have regionally, rather than locally, based administrations even though the dietary services are predominantly locally operated insofar as most institutions have their own catering unit. This factor enables the most senior officers in the dietary and laundry services to have a much stronger position in the board administration than domestics and orderlies for advocating the continuing provision of their respective services by the hospital board rather than by private contractors.

On the above criteria, domestic and orderly services have the same organisational characteristics but the former is contracted out more extensively than the latter. There are at least two important differences between them which might provide some degree of explanation for this. Perhaps the most fundamental one lies in their respective work forces. Orderly work is predominantly and was exclusively, until a few years ago, a male occupation while domestic services have been a female preserve. Although no data is available to verify this contention, its validity is well founded from extensive empirical observation. However any appeal to gender related issues in explaining differential levels of contracting out between the ancillary services would be hard to sustain since dietary and laundry labour forces are also predominantly female and yet are contracted out less than orderly services.

Of possibly more explanatory value is the contention that most domestic (and other) cleaning requirements can be more precisely specified with respect to timings and frequencies than orderly services. The latter can often be required at irregular intervals and at no one set time. Much of the work has to be done on an 'as and when required basis'. An immediate consequence is that it is considerably more difficult to specify

in tender documents the detailed requirements for orderly services than for domestic services.

Whatever the significance of the above factors in explaining the sectoral variation in contracting out, there is still the question of why the process has predominated in the smaller hospital boards. The next section starts to address this issue by first looking at the relevance of institutional size in terms of the theoretical frameworks laid down in chapters two and three.

6.7 Review of Theoretical Considerations:

Within public choice theory it has been seen that state sector managers pursue a policy of maximisation of both budget and bureau size. This leads to the growth of the bureaucracy itself with lowered levels of economic efficiency stemming from the reduced effect of market forces in planning procedures. On this basis it could be expected that the larger the bureaucracy (institution) the greater the oversupply of services in terms of what consumers would require. Therefore more consumer pressure could be levelled against larger institutions to privatise their services notwithstanding the possible loss of scale economies as was noted in the Tieboutian hypothesis in chapter two.

Empirically this effect may be somewhat diluted in the New Zealand context as hospital services, while provided by regional authorities, are financed from the national (central) government. Any direct association between levels of nationally raised taxes and locally provided services may not be so transparent when both the funding and provision is at the sub-national level which was an assumption of the Tiebout model. Nevertheless an association, even if only a weak one, may still be expected between consumer preference for less costly service provision, and hence lower (national) taxes, and privatisation in large public bureaucracies.

The relevance of scale economies to contracting out is apparent in the context of Weberian organisational theory in which privatisation is presented as a form of 'bureaucratic rationalisation'. By the term, scale economies, is meant economies resulting from the changes in the size of an operation or process. Where an organisation is so small that it is not economically worthwhile to provide a service on the grounds of its size, then contract provision is indicated. The process is applicable to the concept of 'bureaucratic rationalisation' in which management personnel adopt privatisation to divest themselves of problems associated with staff/labour force administration. In smaller institutions the operation of scale economies might not justify the employment of industrial relations

and personnel officers specifically for this purpose.

An extension to this argument however is the possibility that larger institutions may have greater levels of labour militancy in the workforce. In this case privatisation could also be resorted to for relieving managers of particularly onerous administrative responsibility rather than realising scale economies. This predisposing factor to privatisation would then outweigh the administrative advantages accruing to larger institutions from employing the industrial and personnel officers.

Size might also be indicative of the level of privatisation when considered in a broadly Marxist framework. In general the larger the institution, the more communication, cohesion and organisational strength of the workforce and hence the association of large work places with a higher level of class conflict than comparatively smaller ones. This supposedly greater level of class conflict could possibly inhibit the implementation of privatisation policies in view of the likely depressed working conditions that would ensue. This argument therefore conflicts with the above managerialist one. The spatiality of privatisation might be expected to reflect differences in the balance of class forces in each region or locality with the largest resistance to privatisation occurring in the regions with the largest institutions.

Summarising then, all three frameworks indicate that institutional size may have an important bearing on the development of privatisation. Yet the theories are at a degree of variance over the direction in which any size factor might operate. For public choice theory a positive correlation might be expected between the level of privatisation and the size of institutions as public dissatisfaction grows with the size of the public bureaucracies. Within managerialism however any possible correlation between size and privatisation cannot be so easily predicted. Managers may privatise at both ends of the size scale; for the achievement of scale economies at the lower end and for relieving industrial relations problems at the upper end.

By contrast a Marxian framework would indicate a clear negative correlation between size and privatisation as heightened labour militancy in the larger institutions might inhibit the process there. It should also be realised that any substantial change over time in institutional size might change the predisposition towards privatisation and therefore alter both the strength and the sign of any correlations. Any likely correlation should therefore be examined across as wide a time span as available data permits.

6.8 Institutional Size and Contracting Out:

The first part of this section attempts to explain the contracting out of services according to hospital board size while the second looks at the possibility of realising economies of scale by contracting out.

6.8.1 Hospital Board Size and Contracting Out Policies:

If hospital boards are grouped according to the number of services they contract out, as shown in table 6.4, a distinct size profile emerges. Total bed numbers of each board are taken as the surrogate for board size and the groupings are given for the same years as in table 6.3; 1976, 1981, 1986 together with 1989 as this is the latest year for which such data is available. As population figures are not being considered there is not the same need to adhere to census years but the same three years are still retained for analysis as they provide a comprehensive coverage of the years in which the major changes in contracting out occurred.

Inspection of table 6.4 readily reveals that in each year considered the largest group of boards, as measured by both mean and median values of bed numbers, is that which contracts out domestic cleaning services alone. Using the same size criteria, the next largest group is that which contracts out nothing at all while the third and fourth ranked group alters from year to year between the groups contracting out domestic and orderlies and the one contracting out all three services. Table 6.4 also reveals that there is a marked variation in board size within each group. Analysis of variance conducted for each year did however show that the mean size variation between the groups was greater than the variation within the groups although statistical significance was not found even at the five percent level for 1989 (see Appendix 1). Clearly although size is a factor in determining the number of services a board contracts out, it does not manifest itself in a simple linear progression of increasing (or decreasing) contracting out with changes in board size.

Two factors may have distorted the above analysis. One is the crudeness of using measures of contracting out based simply on the number of services involved and the other is the neglect of intra-board variations in the process. The four category sectoral classification in figures 6.2 and 6.3 and table 6.4, subsumes many boards with apparently equal levels of contracting out when in fact there may be considerable disparities between them. To investigate the matter further two approaches are adopted. The first involves developing an 'index of privatisation' in which each board is scaled according to both the number of services contracted out and the proportion of total bed space that is served by contractors. The computational details are presented in Appendix 2. In

TABLE 6.4: Contracting Out of Hospital Services and Hospital Board Size

<---------- Services Contracted Out ---------->

None		Domestic		Domestic and Orderlies		Domestic, Orderlies and Dietary	
Hospital Boards	Beds	Hospital Boards	Beds	Hospital Boards	Beds	Hospital Boards	Beds
			1976				
Waiapu	44	Waikato	2,859	Tauranga	411	Bay of Plenty	281
Cook	369	Taranaki	685	Taumarunui	151	Ashburton	285
C Hawkes Bay	197	Wellington	3,003	Marlborough	290	Vincent	86
Nelson	1,161	Canterbury	3,131	Wanganui	875	West Coast	852
Auckland	5,309	S Cant'bury	485	Dannevirke	153	Maniototo	33
Hawkes Bay	859	Palm'st N	1,674	Wairarapa	337		
Otago	2,052			Northland	789		
Thames	332			Southland	772		
South Otago	214			Waitaki	200		
MEAN	1,171		1,973		442		307
MEDIAN	369		2,267		337		281
			1986				
Waiapu	44	Waikato	2,715	Tauranga	414	Bay of Plenty	257
Cook	316	Taranaki	673	Taumarunui	123	Ashburton	228
C Hawkes Bay	174	Wellington	2,606	Marlborough	234	Vincent	79
Nelson	984	Canterbury	3,130	Dannevirke	137	Northland	807
Wanganui	799	S Cant'bury	492	West Coast	673	Thames	291
Palm'st N	1,475	Auckland	4,475	Waitaki	186	South Otago	141
Wairarapa	304	Hawkes Bay	789			Southland	705
Maniototo	46	Otago	1,369				
MEAN	518		2,031		295		358
MEDIAN	310		1,988		210		257

None		Domestic		Domestic and Orderlies		Domestic, Orderlies and Dietary	
Hospital Boards	Beds	Hospital Boards	Beds	Hospital Boards	Beds	Hospital Boards	Beds
			1981				
Waiapu	44	Waikato	2,859	Tauranga	411	Bay of Plenty	281
Cook	347	Taranaki	698	Taumarunui	156	Ashburton	284
C Hawkes Bay	195	Wellington	2,644	Marlborough	303	Vincent	79
Nelson	1,108	Canterbury	3,175	Northland	840		
Wanganui	861	S Cant'bury	503	Thames	309		
Palm'st N	1,661	Auckland	4,975	Dannevirke	149		
Wairarapa	329	Hawkes Bay	782	West Coast	851		
Waitaki	206			Southland	743		
Otago	1,752						
South Otago	181						
Maniototo	46						
MEAN	612		2,228		471		208
MEDIAN	347		2,644		363		261
			1989				
Waiapu	38	Waikato	2,457	Tauranga	386	Bay of Plenty	247
Cook	317	Taranaki	634	Taumarunui	105	Ashburton	234
C Hawkes Bay	195	Wellington	2,444	Marlborough	185	Vincent	67
Nelson	958	Canterbury	2,970	Northland	780	Thames	234
Auckland	4,225	S Cant'bury	488	West Coast	625	South Otago	134
Wanganui	714	Hawkes Bay	716	Waitaki	185	Southland	731
Palm'st N	1,315	Otago	1,300				
Dannevirke	114						
Wairarapa	275						
Maniototo	46						
MEAN	823		1,573		378		275
MEDIAN	296		1,300		286		234

Data source: *Hospital Management Data* 1976, 1981 and 1986 and Department of Health records 1989

the second approach each individual hospital, is considered by correlating the size, as given by total bed numbers, with the number of services privatised. Starting with the first approach, the privatisation indices are presented for all the boards in table 6.5.

From the row of totals at the bottom of table 6.5, it is seen that, the overall level of contracting out, as assessed by this index has remained virtually static over the years. This is not altogether surprising since cases of contracting out in some boards have often been accompanied by reversions to in-house provision in others as described earlier. The lowered 1981 level is explained on the basis of the time lag between the termination and the adoption of contracting out between various boards. It should also be noted however that these privatisation indices do not account for the general tendency towards more competitive tendering instead of negotiated contracting. By performing regression analysis on the privatisation indices for each year, and the board size, as given by total bed numbers, r values of -0.44, -0.30, -0.31 and -0.32 were obtained for, 1976, 1981, 1986 and 1989 respectively. For the 29 cases in the regression, statistical significance only existed for 1976.

When individual hospitals' bed numbers are correlated against the numbers of services they contract out, the r values, presented in the same chronological order as before, are only 0.02, 0.02, 0.06 and 0.06. Even with 165 to 200 cases considered none is significant but this time however all r values are positive. Interestingly no evidence has been found to indicate any contracting out in psychiatric hospitals, which are some of the largest in New Zealand. Ostensibly this has been for security reasons and when these institutions are removed from the analysis the correlation between size and contracting out is slightly stronger. The r values however are still only 0.13, 0.11, 0.15 and 0.14 and again yield no statistical significance.

At the board, or regional, level the correlations are consistently negative, as might be expected if contracting out was resorted to in pursuit of scale economies. The weakness of the correlations for 1981 and 1986 is illustated graphically in figure 6.6 where a very large degree of scattering amongst the hospital boards can be observed. On the other hand, at the hospital or local level the correlations are positive indicating a greater tendency, even if only very slight, to contract out in larger hospitals which contradicts the scale economy argument. Clearly the operation of scale economies in the context of contracting out requires further consideration.

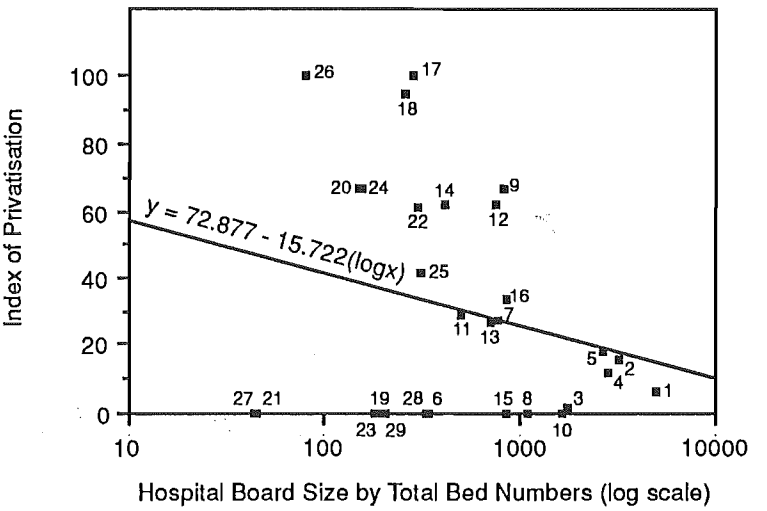
TABLE 6.5: Indices of Privatisation of New Zealand Public Hospital Ancillary Services

Hospital Boards	Privatisation Indices 1976	1981	1986	1989
Auckland	-	6.2	8.9	-
Canterbury	14.6	15.5	16.1	16.5
Otago	1.8	1.7	12.9	15.1
Waikato	11.7	12.0	11.8	12.6
Wellington	15.6	18.4	18.2	17.9
Cook	-	-	-	-
Hawkes Bay	-	27.4	27.4	26.8
Nelson	-	-	-	-
Northland	66.7	66.7	100.0	66.7
Palmerston North	16.3	-	-	-
South Canterbury	28.5	29.2	29.6	29.6
Southland	56.2	61.6	93.2	93.7
Taranaki	26.2	27.0	27.1	28.5
Tauranga	62.5	62.2	62.5	62.3
Wanganui	58.3	-	-	-
West Coast	51.2	33.8	34.5	19.0
Ashburton	100.0	100.0	100.0	100.0
Bay of Plenty	94.3	95.0	95.3	97.6
C. Hawkes Bay	-	-	-	-
Dannevirke	66.7	66.7	-	-
Maniototo	100.0	-	-	-
Marlborough	61.9	61.1	61.3	63.3
South Otago	-	-	68.1	64.2
Taumarunui	66.7	66.7	66.7	66.7
Thames	-	41.8	64.6	73.0
Vincent	100.0	100.0	100.0	100.0
Waiapu	-	-	-	-
Wairarapa	62.7	-	-	-
Waitaki	51.3	-	50.2	50.5
TOTAL	1,049.8	829.6	1048.4	1,004.5

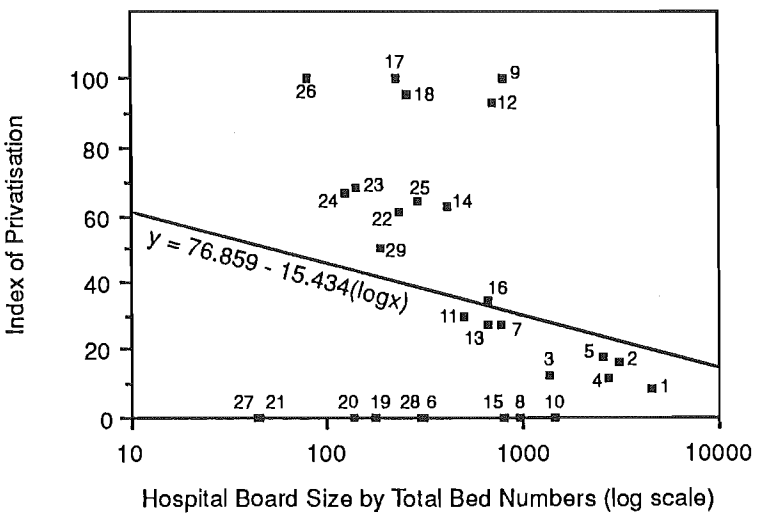
urce: calculated from *Hospital Management Data* 1976, 1981 and 1986 and Department of Health records 1989

Figure 6.6 The Relation between Hospital Board Size and Privatisation of Ancillary Services

1) 1981



2) 1986



Key

1	Auckland	11	South Canterbury	21	Maniototo
2	Canterbury	12	Southland	22	Marlborough
3	Otago	13	Taranaki	23	South Otago
4	Waikato	14	Tauranga	24	Taumararunui
5	Wellington	15	Wanganui	25	Thames
6	Cook	16	West Coast	26	Vincent
7	Hawkes Bay	17	Ashburton	27	Waiapu
8	Nelson	18	Bay of Plenty	28	Wairarapa
9	Northland	19	Central Hawkes Bay	29	Waitaki
10	Palmerston North	20	Dannevirke		

urce: calculated from *Hospital Management Data* 1976, 1981 and 1986 and Department of Health records 1989

6.8.2 Economies of Scale and Contracting Out:

It was seen in chapter five, that where domestic and orderly services were provided by a hospital board rather than by contractors, the services were administered by a (hospital) manager in each of the board's institutions. The smaller boards are structured such that regional (board) and local (institutional) management is combined and almost indistinguishable. These boards tend not to be of sufficient size to merit the employment of a manager specifically for these services. The task therefore has to be performed by administrative staff whose primary function lies in other areas.

A further point to be considered is that in the smaller boards the division of labour is less rigid to the extent that there is often a high degree of coincidence in the work schedules of domestic cleaners and orderlies. In larger boards the two can more justifiably be administered as separate entities and domestic cleaning alone can be contracted out while still leaving an in-house orderly service as a working unit. When the smaller boards contract out domestic services the reduced division of labour in such institutions requires orderly services to be included in the contract. The result is that the latter services are more likely to be contracted out there than in the larger boards.

In the case of dietary services, the reason often cited by management personnel for contracting out these services has been the difficulty of attracting qualified dietitians in small boards. This has primarily been because of the lack of both training schools and further career opportunities in such boards compared to the larger ones based in the main urban centres. Shortage of locally available expertise, largely consequent upon smallness of institutions, has therefore been cited as a major factor in formulating boards' contracting out policies for this service.

The above notwithstanding, it could be said that the scope for achieving scale economies by contracting out ancillary services is really quite limited since, in the case of dietary and laundry services, the plant and equipment have always remained under hospital board ownership. With domestic and orderly services the capital equipment is minimal by comparision, and so in both cases scale economies have been restricted to eliminating the need to employ specialised management personnel. This lack of opportunity for scale economy could, in part at least, explain the weak correlation between levels of privatisation and institutional size. Still left unexplained though is why two boards or individual institutions of similar size and with similar opportunities for scale economies, however

limited, may pursue very different contracting out policies?

Some examples may illustrate the nature of the problematic. On the basis of scale economies in administrative procedures, the eight smallest boards in New Zealand (ie those with less than 200 beds in 1985) should contract out their ancillary services. However two of them have never contracted out any services (Central Hawkes Bay and Waiapu), two have ceased to do so (Maniototo in 1980 and Dannevirke in 1986), another two have continuously used contractors for many years (Vincent and Taumarunui) while the remaining two (South Otago and Waitaki) have respectively started and restarted contracting out in the 1980s.

In the case of Central Hawkes Bay Board the management has claimed that:

> Economic studies based on known contract prices and 'present costs' indicate that for a Board <u>of this size</u>, the contract option is not attractive (written personal communication, 28th April 1989, my emphasis)

By contrast Ashburton and Vincent, which are respectively larger and smaller than Central Hawkes Bay, have both been contracting out their ancillary services at all their institutions for many years. Discussions with the current Ashburton management have revealed that the contract option is attractive mainly for administrative reasons. A reversion to in-house provision would involve them in extra administrative work and so compromise the administration of other areas of activity (personal communication nd).

The contracting out policies of the neighbouring Vincent and Maniototo Boards are interesting to compare. In terms of both district populations and bed numbers the latter is about half the size of the former and reverted to in-house provision in 1980. In mid 1988 the Boards became subsumed under the newly created Otago Area Health Board and, shortly after, the hospitals in both former Boards had their ancillary services put out to competitive tender. The tendering exercises were conducted by the same authority for all the hospitals concerned. While a new contract was let in Vincent, in Maniototo, "*the in-house services were retained when it was established that there was no significant financial advantage to contract out*" (Otago Area Health Board, written personnal communication, 29th September 1988). So why did cost factors alone indicate contracting out in Vincent but not Maniototo?

When previously under contract, the former Maniototo Board management maintained that, the contractor's 'overhead' costs made the final contract price appear uneconomic compared with in-house provision (personal communication, nd). The contract was therefore terminated. An

examination of the geographical location of the two Boards' hospitals in relation to the contract company's branch office lends weight to this argument. The relationship between size and contracting out may therefore be mediated by locational factors.

6.9 Contracting Out and Geographical Location:

The above comparison of Vincent and Maniototo may usefully be taken further by considering their spatial 'accessibility' to contractors. If Ministry of Transport recommended road travel times[6] are used as a surrogate of spatial 'accessibility' then it is seen that Ranfurly Hospital (Maniototo) is 1hr 30min (88km) from Clyde where the contractor's branch office was in 1980. Also at Clyde is Dunstan Hospital (Vincent) and just 25min (21km) travel time away is Cromwell Hospital (Vincent) but in the opposite direction from Ranfurly. Clearly servicing contracts in Maniototo involved transportation (overhead) costs that were not incurred in Vincent.

Since the reversion to in-house provision in Maniototo, the contracting company (Crothalls) has relocated its branch office to Cromwell and diversified into cleaning private sector commercial premises. It has acquired (non - hospital) contracts in Wanaka, Queenstown and Alexandra at, respectively, 50, 55, 35 minutes journey time from Cromwell but still none in Ranfurly (1hr 45min) away. There has therefore been no scope for reducing contract overhead costs to the Maniototo Board in a way that has been possible in Vincent. Serving Ranfurly hospital would still be time and resource consuming compared to the more locally based contracts.

Two factors seem to be relevant here. First, is that the likelihood of a board contracting out may be dependent upon the distance or 'accessibility' from a contractor's branch office and second, is the existence of other contract work in the locality of the board. In this way the diverse situation of Ashburton and Central Hawkes Bay may be explained. A town of 15,000 (Ashburton) just 1hr 5min (86km) distant from a city of 300,000 (Christchurch) should have far greater business oportunities for contractors than a town of only 5,000 (Waipukurau) with neighbouring cities of just 60,000 (Palmerston North), 1hr 40min (108km) distant and 50,000 (Napier), 1hr (70km) distant. On the basis of locational factors alone a similar sized contract in both boards might therefore be expected to be considerably cheaper in Ashburton than in Central Hawkes Bay. The appeal to the factors of 'spatial accessibility' as measured by road travelling time and 'business opportunity' as indicated by settlement size may also explain the lack of contractors at Te Puia hospital in the Waiapu Board.

In order to see how these two factors mediate the spatiality of

contracting out across the entire country, the above correlation analyses of hospital size and services privatised were reconsidered by deleting hospitals considered both inaccessible and lacking further business oportunity. Albeit somewhat arbitrarily those hospitals selected for deletion were all located in settlements of less than 5,000 people (business opportunity factor) and were more than half an hour (30 minutes) travelling time from a settlement of at least 10,000 people (accessibility factor). With these adjustments to the data, and with psychiatric hospitals excluded, the correlations obtained were little different from before with r values of 0.09, 0.06, 0.16 and 0.15 and still with no statistical significance. Table 6.6 presents all the r values of the above analyses in tabulated form. The consistently low values obtained, despite the various refinements to the input data, shows that there is much left unexplained. Some concrete examples illustrate this.

TABLE 6.6: Results of Correlation between Instutional Size and Levels of Contracting Out

Number of Services Privatised Correlated with:	r values obtained: 1976	1981	1986	1989
Regional Hospital Boards	-0.44	-0.30	-0.31	-0.32
Significance of r with 29 cases		0.3494 at 5% and 0.4487 at 1%		
Individual Local Hospitals	0.02	0.02	0.06	0.06
Significance of r with 165-195 cases		0.1946 at 5% and 0.2540 at 1%		
Psychiatric Hospitals deleted	0.13	0.12	0.15	0.14
Significance of r with 155-185 cases		0.1946 at 5% and 0.2540 at 1%		
Psychiatric and inaccessible Hospitals deleted	0.09	0.06	0.16	0.15
Significance of r with 90-106 cases		0.2050 at 5% and 0.2673 at 1%		

Appealing to size and locational factors does not so easily explain the absence of contractors in the hospitals of the Cook and Nelson Boards. The hospitals of these Boards are both very distant from the nearest major urban centre (respectively, 6hr 30min (386km) from Hamilton and 6hr 55min (417km from Christchurch), but their main centres of population with

32,000 (Gisborne) and 44,500 (Nelson) both support several contract cleaning firms, including Crothalls. Consequently excessive overhead costs should not be an inhibiting factor to contracting out. Also on the basis of the above criteria the existence of contract provision is not readily explained at Balclutha (4,500 population) in the South Otago Board and at Taumarunui (6,500 population). Both are small settlements with little scope for further business opportunity and are distant from their nearest major urban centre; the former 1hr 10min from Dunedin and the latter 2hr 50min from Hamilton. In neither case is contracting out indicated on purely locational factors.

Apart from these two cases, the contracting out of the laundry service at Kaikoura Hospital in the Canterbury Board is also instructive. In this example contracting out was resorted to because of, and not in spite of, locational inaccessibility. The cost of transporting laundry 200km or 2hr 55min to, and from, the Board's central linen department in Christchurch made contracting out to a local Kaikoura firm economically attractive. All other supplies for the hospital were transported from Christchurch under contract with New Zealand Railways. Substantial increases in freight charges in 1988 resulted in there being financial advantages for the Board to operate its own freight service between Kaikoura and Christchurch. As a consequence the laundry could also be carried for virtual zero opportunity cost and the contract option was no longer so attractive. So while geographical location was problematic for services under one set of conditions, it ceased to be when the conditions changed. This final example shows the difficulties of using purely locational factors as explanatory variables in the uneven development of privatisation.

Summary and Conclusion:

From the analysis of contracting out undertaken in this chapter two broad trends have been identified. One is a progressive decrease in the extent of contracting out from domestic cleaning through to laundry services and the other is a slight overall increase in the process with decreasing size of hospital board. This tendency is mediated to a certain extent by some small boards' distant location from major centres of population and lack of further business opportunities for contractors in these board localities. Even within large boards, many of the very small hospitals do not have contract service provision. Institutional factors based on size and geographical location cannot be altogether ignored in efforts to explain the uneven development of the contracting out. However the existence of numerous contradictory cases has rendered problematic all attempts to establish normative criteria upon which to explain the uneven

spatiality of the process on a broad nationwide geographical scale.

Significantly missing from the debate so far has been the issue of socio-economic and political factors within both the institutions themselves and in society as a whole. By focusing on just locational or institutional factors, the analysis presented has been socially static. The first part of this chapter showed that contracting out of hospital ancillary services has developed over a long period of time with many changes in policy which cannot be fully explained by appealing to analyses devoid of social context. As the theoretical frameworks of this thesis indicate, other factors must also be considered in the development of privatisation, such as political and financial pressures on bureaucracies to privatise their activities and the class conflicts engendered in the resistance to the implementation of these policies. It is towards addressing these issues that the next three chapters are devoted.

Footnotes:

1 The methodology adopted in the search for data and information for this thesis is detailed in Appendix 4.

2 The term 'general' is used as a distinction from specialised hospitals typically, psychiatric, maternity and geriatric.

3 Forms of Contract: There are three main forms of contractual arrangement for providing a service. Under a full contract, the ownership of capital equipment, the employment of the labour force and the management of that labour and capital is transferred to the contractor. With a management only contract the contractor has the responibility for manageing the service, while the institution retains the employment of the labour force and the ownership of the plant and equipment. A labour only contract may include the management of the service as well as the employment of the work force but specifically excludes plant and equipment.

4 ADT was founded in 1914 in the USA as American District Telegraph.

5 Major urban areas refer throughout this thesis strictly to the cities of Auckland, Hamilton, Palmerston North, Wellington, Christchurch, and Dunedin.

6 Data is taken from the Shell Oil Company, *Road Atlas of New Zealand*, (1982, 7) and is supplied by the Ministry of Transport.

CHAPTER 7

The Early Development of Contracting Out Public Hospital Ancillary Services

Prior to the 1980s privatisation has generally been considered as only having taken place in a minimal and piecemeal manner without much of the currently associated political and economic pressures for its implementation. Any detailed examination of the process within this period has therefore tended to be eschewed. In the previous chapter it was seen that contracting out by the state to the private sector had origins in the New Zealand public hospital system going back to the 1940s. The analysis of contracting out presented hitherto has examined the situation only at certain points in time. In this chapter the intention is to provide an explanatory account of the on-going development of the process upto the end of the 1960s. The time span chosen is not arbitrary since, as has just been seen, the development of contracting out exhibited a much greater geographical complexity in the 1970s and therefore requires a separate analysis.

After a brief discussion of the sources of reference for this chapter, attention centres on the historical origins of contracting out public hospital ancillary services and the socio-economic conditions which led to its expansion and entrenchment. This is followed by attempts to explain theoretically the spatially uneven development of private provision. Regional variations in the structure of the labour market are examined in relation to the spatiality of contracting out. Drawing on some of the discussion in the previous two chapters the differences across space in the institutional structures of hospital boards are examined and this is followed by a discussion of the likely political pressures at both national and regional level for contracting out. The chapter concludes by assessing the explanations advanced for contracting out, and its uneven spatiality, in terms of the theoretical frameworks established for this thesis.

7.1 Sources of Reference:

Although the history of privatisation in New Zealand hospitals only extends back to the late 1940s many difficulties were encountered in regard to finding relevant data and information. Written records of hospital boards and the major contractor involved are generally incomplete and in some cases, where boards had ceased contracting out several years ago, they have been completely absent. Even where the original contracts and tender documents still exist there is often little supplementary information relating to the circumstances under which contracting out was initiated and, in some cases, subsequently abandoned. Sometimes information on relatively recent years was no longer available as many

records had been destroyed. The following account therefore has had to be based on what few documents have been preserved together with the personal experiences of managers and workers with long service records in the industry.

Fortunately there exist two original sources of reference, still largely intact, from which some detailed information was able to be derived on the historical origins of contracting out hospital services. The first is a *Memorandum to all Members of the* [Waipawa'] *Board in Reference to a Proposed Special Meeting of the Finance and General Purpose Committee* to be held on 30th November 1948 (WHB 1948). This memorandum, on the issues to be considered in the private provision of hospital ancillary services, was compiled by the management staff of Waipawa Hospital Board, and is almost complete. The memorandum is especially useful as it details of the experiences of several other hospital boards with contracting out their ancillary services.

The second major source of information is a *Review of Contract Cleaning* prepared by the North Canterbury Hospital Board for a meeting of hospital board representatives held in Wellington on 17th October 1952 (RCC 1952). Apart from these lengthy reports the only other material available that refers to this and subsequent periods is what still remains of letters that have been exchanged between the boards themselves and with the contractors. Some of the early promotional literature of the contractors still survives and provides a useful source of reference as does some of the written communications with trade unions in more recent times. Basically however there is a great deal of incompleteness in existing records. Nevertheless in spite of the general lack of recorded information some useful observations can still be made regarding the origins of contracting out of New Zealand hospital ancillary services.

7.2 The Historical Origins of Contracting Out Hospital Services in New Zealand:

The overall social context within which contracting out took place can be ascertained with a considerable degree of certainty. Some passages from the detailed historical account of the development of the New Zealand Nurses' Association by Pitts (1984) are illuminating as is a short article from the *New Zealand Nursing Journal*, (NZNJ April 1959). From around the time of World War Two onwards many hospital boards started to contract out to the private sector some, if not all, of their requirements for both domestic services such as general cleaning, table waiting in nurses' homes and ward dishwashing and, in some cases, orderly and dietary services. Prior to the advent of contracting out much of this work was done by

nursing staff.

During World War Two hospitals experienced an acute shortage of labour due to military service requirements. The years immediately after the War also saw a serious shortage of nursing staff in hospitals owing to the additional expansion of public health, plunket[2], district, and industrial nursing services (Pitts 1984, 53). Demographic factors, such as the post war 'baby boom' and the lower birth rate of the 1920s compared to previous decades, served to increase the demand for nursing services while at the same time there was a decreased supply of potential recruits. Concern over nursing staff recruitment and retention, which was by no means just confined to New Zealand but world wide, led to a considerable reappraisal of the role and professional standards of nursing. An outcome was the widespread use of auxiliary (ancillary) workers who undertook what were considered non-nursing duties to help with staff shortages (Pitts 1984, 54). According to the NZNJ (1959, 39):

> ...the ward cleaning duties formerly done by the nursing staff such as cleaning of toilet units, all dusting and polishing of ward and office furniture has been taken over in some hospitals by auxiliary workers. In others those duties have been handed over to the Commercial Cleaners Company.

Under this latter situation the duties were then contracted out to the private sector. Finding alternative sources of labour to do these non-nursing duties was indeed a major problem to the hospital boards. The choice was either to employ labour directly for this specific purpose or to hire specialised contractors from the private sector. The decision to opt for contract rather than directly employed labour, appears to have rested upon one fundamental premise. This was to divest the boards' management staff of the administrative problems related to recruiting workers in times of general labour scarcity. This scarcity existed, not only in nursing services, but virtually throughout the entire economy and will be examined further presently.

Whether it was thought that contractors could overcome the problem of labour shortage more easily than the boards themselves is not altogether clear. One reason cited for this possibly being the case is that contractors, being in the private sector, could pay higher wages than the minimum set by the national award coverage for hospital ancillary workers which was only established in 1947 (Ferguson 1985, 156). The boards on the other hand have always been constrained by central government regulation to adhere to these minimum levels. While contractors are believed to have paid more than award wages from time to time, the only evidence found to verify this was at the Auckland Hospital Board in the

late 1940s. According to its Secretary (Chief Executive), "*although the contractors offered as much as 30s per week more than* [the] *Board had been permitted to offer,* [the contractors] *were unable to obtain sufficient employees*" (WHB 1948, 9).

Another important factor in the resolution of the labour shortage problem is that contract services may often have involved a higher degree of labour productivity than boards and so more could be done with the same number of workers. This is revealed in a submission from the North Canterbury Hospital Board[3] to the 1948 *Memorandum*.

> [The contractors] immediately eliminated the divided duty (which was a source of annoyance to the average hospital worker) and started a system of full day, half day and so many hours and did the cleaning, polishing and scrubbing with up to date machines (WHB 1948, 11).

Whatever the extent of the higher labour productivity with contract provision, the crucial factor for hospital boards was that contracting out rid them of the problem of finding labour to provide an adequate service. The secretary of Wanganui Hospital Board writing in 1948 stated that:

> The contractors in this city [Wanganui] appear to have had no difficulty in obtaining sufficient staff but one of the advantages of the service is that this particular problem is no worry to the Board. If sufficient staff is not available, the work is done by the supervisor or manager and the staff that is available even though it may necessitate unduly long hours (WHB 1948, 12).

In the same report the secretary of Taranaki Hospital Board argued in a similar vein:

> The matter of obtaining sufficient staff is entirely the responsibility of the contractors who in terms of the contract are required to render an adequate service. Should they experience shortages of staff (which they have done on occasions) their supervisors work extra hours and they make use of part time labour. However the worry is theirs and has not so far had any undesirable consequences as far as this Board is concerned (WHB 1948, 13).

In spite of these possible advantages, all the existing evidence indicates that boards were very reluctant to contract out these services and they viewed the process as only a temporary expedient while severe staff shortages obtained. The main reasons for the reluctance seems to have been based on the higher cost of contract vis-a-vis board provided services. The loss of any direct control over the labour force through contracting out was also cited as an inhibiting factor on occasions. No evidence however exists of trade union influence or labour force agitation having any effect on the decision to contract out. This is most likely to

be explained on the grounds that contracting out at this time involved no job loss or reduction in working conditions. At this stage the only two parties involved in the process appear to have been the hospital boards' management structures and the contractors.

Some of the comments made by the secretaries of the various hospital boards as recorded in the 1948 *Memorandum* illustrate the reluctance to contract out. For example Palmerston North Hospital Board claimed that the contract system was adopted only, "*as a last resort and that it was much more expensive than the staffing* [ie in-house] *system*" (WHB 1948, 10), while the secretary of the Wellington Hospital Board was of the opinion that:

> The contract system was not comparable with the staffing system and although owing to staff shortages it had been forced upon the Board, should staff become available the old system would be reverted to at the earliest moment. He [the secretary] also stated that the contract system cost considerably more than did the staffing system (WHB 1948, 10 my emphasis).

The Wellington Board gave no indication in the report as to how much more contracting out cost but, again with reference to the Auckland Hospital Board:

> Although the contract price was more than 10% greater than what it had cost the Board previously, the service never functioned properly and after three months it broke down altogether, with the result that the contractors asked to be relieved of their contract (WHB 1948, 9 my emphasis).

It seems that Auckland was somewhat exceptional in that, according to the Board Secretary, it was probably the worst off place in New Zealand for housing while there was a ready availability of industrial work to attract potential hospital workers. Largely as a consequence of this experience the Auckland Board initiated a special training course for domestic workers. In order to attract staff a career structure was established, "*with promotional prospects to that of institutional housekeepers at salaries of up to £450 per annum*" (WHB 1948, 9). No other board in New Zealand has ever undertaken such a procedure, possibly because the early experience with contracting out was not so disastrous.

The North Canterbury Hospital Board, one of the earliest to contract out some of its ancillary services, is reported as saying that it would still recommend, "*reversion to the staffing system if it were possible to obtain adequate staff*" (WHB 1948, 11) if only because of the cost involved. In the words of the Secretary of the Board, "*Contract Cleaners Ltd. are not in this game for the good of their health and broadly they work on a 10%* [profit] *margin*" (WHB 1948, 11). The Marlborough Hospital Board stated in a letter of 14th May 1951 to the Waipawa Hospital Board that its present

contract, "*was based on a ceiling rate of £9,828 per annum as from 1st November 1949 which we estimated at the time was about £500 more than we could render the service for ourselves*". Payment for contractors' profits and higher wages meant that contracting out was not economic compared to provision by the boards themselves.

By contrast other boards, such as Waikato and Wanganui, reported that the difference in costs between in-house and contract labour was similar if slightly in favour of the latter. "[T]*he contract rate of the Waikato Hospital* [Hamilton] *for the ensuing three years has recently been fixed at £24,727, whereas our own estimate of the total cost for the period given (when we could obtain the staff) was £24,767*" (WHB 1948, 13). In this case it was reported that the introduction of contractors had been most beneficial in relieving junior nursing staff of domestic duties, and for this reason it was thought likely that the system would continue. Wanganui Hospital Board estimated a money saving of only £100 per annum through contracting out but maintained that the avoidance of administrative work achieved by the process would reveal greater savings, although no data was presented in the 1948 *Memorandum* to justify this claim.

Difficulties in presenting more detailed and accurate assessments of the cost difference between in-house (board) and contract (privately) provided services seem to have arisen for two main reasons. First is that on account of the labour shortage most hospitals were being staffed below what was deemed a desirable level and hence an estimate had to be made of what the cost of providing the service would be if fully staffed. A second difficulty expressed by boards was the way in which the contractors set the "ceiling price" or maximum price on their quotations. It was established on a cost plus basis insofar as the boards were required to pay the contractors according to the precise number of staff employed and the hours worked. Concern was expressed at this method of pricing since, according to the Secretary at Waipawa Hospital Board, "*I cannot nominate any ways and means of arriving at the cost as to do so would mean having a strict check on the number of hours worked by each member of staff which would be impossible and would mean accepting the Commercial Cleaners Ltd figures*" (WHB 1948, 8). As will be seen in the next chapter this issue still presented difficulties well into the 1980s.

Those boards that desisted from contracting out, at this stage at least, seem to have done so mainly on the grounds that the labour shortage problem in their respective hospital districts was not so critical as to merit this policy. The Cook Hospital Board stated that it was not prepared at this stage to assign, "*to a profit making concern work which should be*

carried out directly by the Board....[and]*... that although staff difficulties were experienced, at no time had the position become acute*" (WHB 1948, 9). Similarly at Wairarapa in 1948, the Board was not prepared to consider contract cleaning unless the staffing situation, "*deteriorated much more seriously*" (WHB 1948, 12) while Hawkes Bay Hospital Board explained its decision to retain ancillary services in-house on the grounds that, "*So far we have managed to scratch along as the staffing position in Hawkes Bay although difficult is not embarrasingly so*" (Letter to Wairarapa Hospital Board, 1st May 1951).

It would appear, therefore, that the decision to contract out or otherwise depended upon whether the administrative burden of finding domestic staff outweighed the cost involved. Privatisation through private contracting at this time was certainly not a matter of economic expediency and for the most part it was an expense rather than a monetary saving. The 1948 *Memorandum*, from which the above account has been based on, was made only a very short time after many boards had started to opt for privately provided services. It was therefore too soon to assess the standard or level of service provided vis-a-vis in-house provision. This issue was taken up in the 1952 *Review of Contract Cleaning* referred to above. In addition to discussing further the costs of contract services, an examination was made of the standards of efficiency in cleaning services and the terms of the contracts themselves. It would appear that this *Review* was the basis for the consolidation and subsequent growth of contracting out hospital ancillary services.

7.3 The Consolidation of Contracting Out Policies:

By the time of the 1952 *Review*, prepared by the North Canterbury Hospital Board, contracting out had been established for a few years in some boards. The stated task of the meeting for which the *Review* had been prepared was, "*to give some guideline as to the future procedure - either to return cleaning to our* [the boards'] *own control or to improve the contractors service*" (RCC 1952, 2). The position of the North Canterbury Hospital Board at the time was that private contracting could not be dispensed with. This was presumably because of the insufficiency of available labour although this point was not made clear in the *Review*. What was made clear was that the Board was still considering at least a partial reversion to in-house provision since, "*in due course the* [North Canterbury Hospital] *Board may take back the cleaning of one of its smaller institutions which would be used as a testing ground to determine how far the Board could extend its own activities*" (RCC 1952, 2). This possibility however did not eventuate and the decades of the 1950s and 1960s was one of

consolidation in which contracting out became entrenched in the New Zealand public hospital system.

From the 1952 *Review* the main reason for the continuance and consolidation of contract services appears to have been the general satisfaction at the standard of service rendered notwithstanding the already referred to contract failure in the Auckland Hospital Board. The satisfaction expressed however was by no means unqualified. A critical factor identified in achieving the requisite level of service was that of contract supervision, an issue still of paramount concern to hospital managers at the end of the 1980s. Supervision was identified by the 1952 *Review* as being of two kinds; the supervision of staff in the performance of their duty and the supervision of the standard of cleanliness. Albeit reluctantly, many boards were seeing the need for quality control assurance where contractors were involved. Even though the *Review* stated that, "*it should not be necessary for a member of the hospital staff to have to point out uncleaned or poorly cleaned areas*" (RCC 1952, 2) there was invariably a need for just such a measure.

The basis of the need for supervision of staff seemed to arise, not so much from any need to discipline a recalcitrant labour force, but rather to train the staff in appropriate work methods. Writing a few years after the 1952 *Review*, the Domestic Superintendent at Christchurch Hospital commented:

> As far as standards go, medical and nursing standards of cleanliness as applied to hospital wards are always difficult to impose on lay staff who do not fully appreciate the necessity for all surfaces to be clean. The standard of cleaning achieved in the past was higher because it was carried out very largely by the nursing staff as part of their routine work but the methods used now are very much better than those used formerly, for example, the vacuum sweep (letter to Secretary of North Canterbury Hospital Board, 20th July 1956).

It would appear from this statement that improved technology had somewhat deskilled the task of hospital cleaning to the point where untrained staff could be used without seriously compromising standards of cleanliness.

Just as in 1948 the economics of contracting out were still of great concern in the 1952 *Review*. The North Canterbury Hospital Board presented to the meeting a contract labour schedule in use at one of its institutions together with a similar schedule for the cost of performing the same service in-house. These two schedules are produced in full in table 7.1 as they indicate the way in which cost comparisions were derived between private (contractor) and public (hospital board) provision. Although the Board claimed that it was entirely satisfied with the contract,

notwithstanding its cost plus basis as table 7.1 shows, it stated that, "*in this rough costing it appears that a saving of just on 3% could be made if* [the service was] *done in-house. If this were applied to the whole of the Board's contracts, the annual saving would be approximately £1,864*" (RCC 1952, 3).

TABLE 7.1: Comparison of Contract and In-house Cost of Service Provision for a New Zealand Public Hospital in 1952

Provision by Private Contractor		
Supervisor	1 full-time at £8/ 3/ - per week	£ 8- 3- 0
General Duties	3 full-time at £7/11/ 6 per week	£22-14- 6
Relievers	2 full-time at £6/ 7/10 per week	£12-15- 8
		43-13- 2
Additional Holiday Pay Insurance, Employers Liability		£ 3- 7- 2
Insurance, Public Risk Materials and Cartage		£ 1-18- 8
Advertising		1- 6
	Direct Costs	£49- 0- 6
Additional Overhead and Profit Margin (19% - Overhead	£5-17- 8	
Profit	£3- 8- 8	£ 9- 6- 4
		£58- 6-10
Provision by In-House Staff		
General duties	3 full-time at £ 7/11/ 6 per week	£22-14- 6
Relievers	2 full-time at £ 6/ 7/10 per week	£12-15- 8
Part time workers	2 for 4 hours each at £ 4/ 8/- per week (including dish-washing and Sundays)	£ 8-16- 0
Polisher	1 for 4 hours at £ 4/ 4/- per week (including Sunday)	£ 4- 4- 0
		£48-10- 2
Additional Holiday Pay and Employers' Liability Insurance, Material, Cartage and Advertising (as for Contract)		£ 3-15- 8
		£ 2- 0- 2
Additional 40 percent of contract overheads for supervision, depreciation, repairs, etc.		£ 2- 7- 0
		£56-13- 0

Source: *Review of Contract Cleaning* 1952.

The Board concluded from this that the small saving would not justify taking the service back in-house but went on to add that, "*if to this*

saving in cost were added the advantages accruing from regaining full control over all cleaning services, the changeover might be worthwhile" (RCC 1952, 3). The advantages of regaining full control were not spelt out in the *Review* but it seems that providing the cost did not become prohibitive and the standard of service remained acceptable then, for North Canterbury and most other boards, there was insufficient justification for reverting to in-house provision.

Another issue raised in the 1952 *Review* was that of domestic staff accommodation. A reason advanced by some boards in favour of retaining contract services was that they would not have to sustain the expense of providing living quarters for the staff concerned. It was argued by some that the capital, maintenance and interest costs of providing extra residential accommodation to attract or retain staff tipped the balance strongly in favour of remaining with contract services. Other boards, such as North Canterbury, argued that this point was an irrelevance in view of the cost plus nature of the contracts involved:

> [The contractor] could engage only non-resident staff (if possible) and pay transport charges or it could arrange hostel accommodation of its own. In either case, as the contract is a cost plus one, any additional charges fall back on the Board so that the final result would not be greatly different than if the Board had provided the same facilities for its own staff (RCC 1952, 4).

Basically staff accommodation was only a problem to the extent that it represented a financial cost, whether real or imagined, to the boards. It cannot therefore be separated from economic factors in decisions over whether to commence or cease contracting out.

Once the decision had been made to contract out, the privatised system seemed to generate a certain administrative inertia on the part of the boards towards any reversion to the previous system of in-house provision. But underpinning the entire development of contracting out appears to have been the difficult labour supply problem. Simply to state this factor, however, gives no consideration to either the socio-economic context in which labour shortages developed or the possibilities of political pressures for privatisation. Also requiring investigation is how these factors may have affected such uneven geographical development in contract service provision.

7.4 The Uneven Spatiality of Contracting Out prior to 1970; Towards A Theoretical Perspective:

In the following three sections the intention is to explain the geographical basis to contracting out in a more theoretical context. The section examines, sequentially, the macro-social environment, the

institutional structures in existence, and finally local and national political considerations.

7.4.1 Socio-economic factors:

Perhaps the most significant feature of the development of contracting out in this period, when compared to the 1980s, was that it occurred in period of unpredecented and hitherto unsurpassed economic expansion. According to Fougere (1984, 78), the Labour Party was first elected to power in 1935 to relieve the distress of the Depression and in the late 1930s the Government acted to stimulate economic recovery. The implementation of reflationary measures, together with capital flight from the country through distrust of the governments policies, soon led to problems with the balance of payments. The remedy adopted by the Government was the imposition in 1938 of exchange controls and import licences (Fougere 1984, 78).

Under this regime a round of import substituting industrialisation began which provided a considerable demand for labour, both male and female, skilled and unskilled. This industrial growth, which commenced during the War, expanded considerably afterwards and in a 1973 report by the Australia and New Zealand Bank (ANZ, 1973):

> In earlier post war years, import restrictions and difficulties in obtaining overseas supplies stimulated domestic industry and encouraged overseas firms to establish their own plants in New Zealand or to arrange for manufacture of their products by local firms (ANZ 1973, x).

On this basis the number of people engaged in manufacturing almost doubled between 1946 and 1970 although taken as a percentage of the workforce the increase was much more modest (table 7.2).

TABLE 7.2: Employment in New Zealand Manufacturing Industry - 1946-70

Year Ending March	Persons Engaged in Manufacturing (000s)	Total Workforce (000s)	Percentage of Total Workforce Engaged in Manufacturing
1946	124.9	707.9	17.6
1950	133.2	735.9	18.1
1955	153.6	813.9	18.9
1960	156.8	875.6	17.9
1965	192.0	991.4	19.4
1970	229.1	1,090.7	20.2

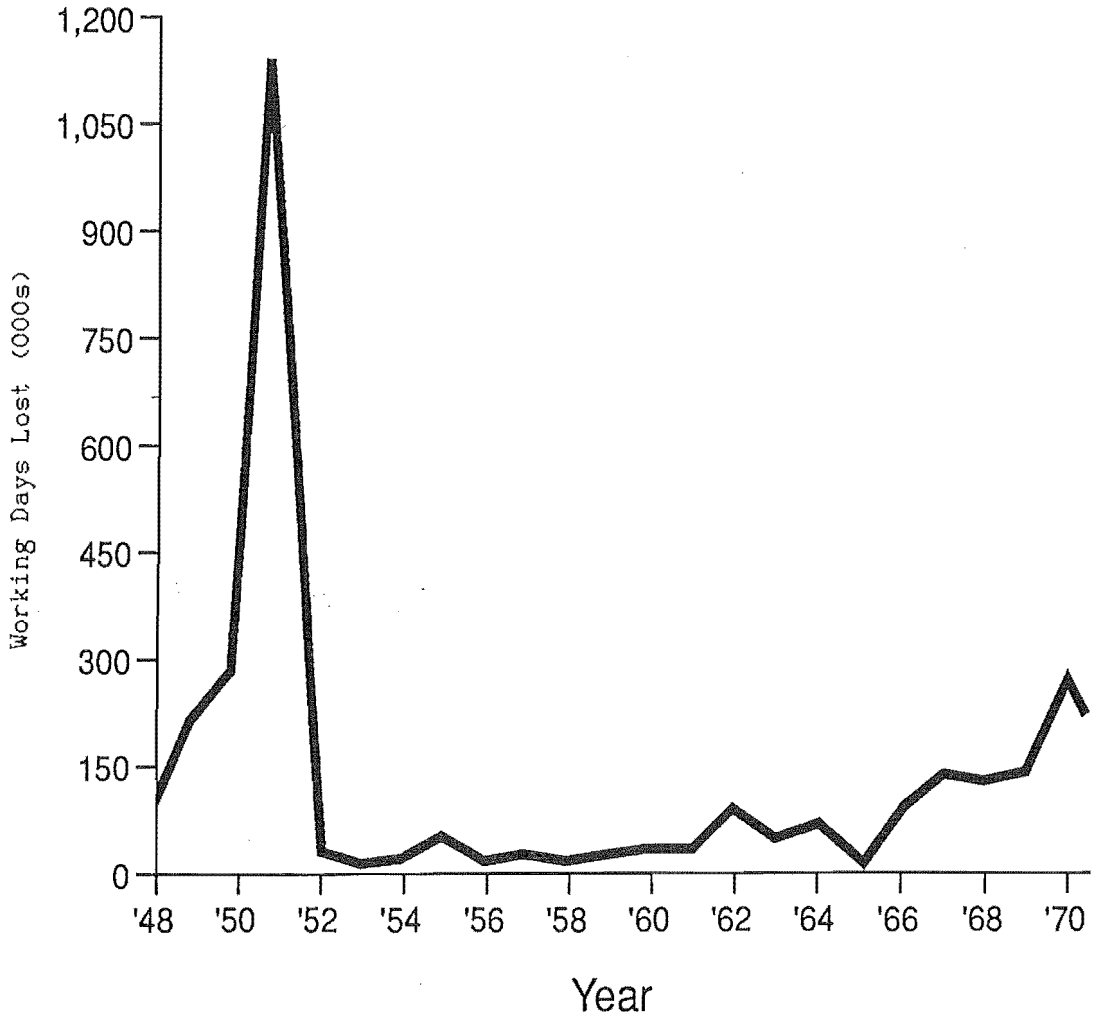
Data source: *New Zealand Official Year Book*, 1976 and 1981.

Unemployment, as measured by official statistics, was virtually non-existent and the period was characterised by an overall shortage of labour throughout the economy which provided the primary rationale for contracting out certain hospital services. It is also apparent from various editions of the *Labour and Employment Gazette* in the 1950s that the situation of almost full employment and high labour turnover was a problem for employers owing to the difficulty of instilling workplace discipline. Such difficulties stimulated the *Labour and Employment Gazette* in 1956 to publish two articles whose titles succintly capture the nature of the situation - 'The Problem of Full Employment' (LEG, November 1955, 48-9) and 'Making Better Use of Our Labour Force' (LEG, February 1956, 13).

This 'problem' of full employment, which was seen to underpin the workforce discipline problem, existed in spite of there being very little industrial activity or union militancy with the exception of a prolonged waterfront dispute in 1951. Figure 7.1 illustrates graphically that the 1950s and most of the 1960s were decades of industrial tranquility and, as far as can be ascertained, there was no industrial action at all in public hospitals during this period. Nevertheless employers often had difficulty in obtaining what they desired in the way of 'reliability' and 'responsibility' amongst the workforce at a time when the normal disciplinary mechanism of dismissal, or threat thereof, was not such an effective remedy in view of the labour shortage. This situation also seems to have applied in the hospitals judging from fragments of existing records.

The nation wide labour shortage however was neither sectorally nor spatially uniform. Although employment data for the period prior to 1970 is sparse certain impressions can be gained. Taking published data on industry job vacancies as a surrogate for labour shortage, the *Monthly Review of Employment* for 1948 shows considerably fewer vacancies for both male and females in the primary sector compared to both the secondary and tertiary sectors (table 7.3). Female vacancies in hospitals (table 7.4) ranked as the most numerous in the tertiary sector at this time although no indication is available as to the particular kind of staff required. As the existing records indicate that most hospital ancillary services were performed by women, the data may go some way towards verifying the existence of a labour shortage in these services. It must be emphasised that the data is given only in terms of job vacancies 'notified' by employers to the Department of Labour and so there is likely to be much under enumeration[4]. The data should therefore be treated with caution.

FIGURE 7.1: Industrial Disputes between 1948 and 1970



Source: ANZ 1973, 82

TABLE 7.3: Notified Vacancies in Industrial Sectors - 30th November 1948

Industrial Sector	Male	Female	Total Male and Female
Primary	787	20	807
Secondary	5,547	5,874	11,421
Tertiary	5,014	4,243	9,257
Total All Industries	11,348	10,137	21,485

Data Source: *Monthly Review of Employment*, November 1948, Department of Labour, Wellington.

This sectoral distinction of job vacancies clearly shows that the main demand for labour was in the manufacturing and service industries. It is perhaps not surprising, therefore, that the regional job vacancy profile shows a distinct urban bias. Unfortunately, for 1948 the regional disaggregation of the data, which is by the former Department of Labour's employment districts, only gives standarised figures (ie vacancies per 1,000 of the surveyed labour force) for males. In view of the high proportion of females employed in hospitals this might not give an accurate representation of the labour shortage situation in this sector of industry. Nevertheless there is some data from the mid 1950s which presents a standarised job vacancy profile for both males and females by geographical region (table 7.5).

This time the somewhat more accuarate 'survey' vacancy rather than 'notified' vacancy data is used. Except for males in October 1956, vacancies per 1,000 employees were greater in the main urban districts compared to the remainder of the country. Even here caution should still be exercised in interpreting the data as the Labour Department's survey as it did not include seasonal industries many of which would be based outside the main urban areas[5]. Notwithstanding this limitation, the regional job vacancy profile may at least partially account for the early growth of contracting out by hospital boards even if the attempt made in Auckland was abortive.

The seeming anomaly of the Auckland Board becomes clearer on examination of the regional job vacancy figures. In both October 1955 and 1956, the Auckland employment district, which is almost conterminous with the Auckland Hospital Board district, shows the lowest job vacancy figures

TABLE 7.4: NOTIFIED VACANCIES IN THE TERTIARY SECTOR OF NEW ZEALAND INDUSTRY NOVEMBER 1948

	MALES				FEMALES			
	Total Unsatisfied at 31/10/48	Notified During Month	Satisfied or withdrawn during month	Total Unsatisfied at 31/11/48	Total Unsatisfied at 31/10/48	Notified During Month	Satisfied or withdrawn during Month	Total Unsatisfied at 31/11/48
TERTIARY INDUSTRY								
Transport and Communication								
Transport and Communication	2,238	363	330	2,271	133	45	38	140
Road, water, air transport	91	29	19	101	20	5	10	15
Post and Telegraph	597	98	54	641	74	19	21	72
Sub-total	2,926	490	403	3,013	227	69	69	227
Distribution and Finance								
Wholesale and retail trade	545	223	186	582	552	129	168	513
Finance and insurance	164	37	8	193	148	18	13	153
Other agencies	87	29	3	113	78	29	34	73
Sub-total	796	289	197	888	778	176	215	739
Domestic and Personal Services								
Hotels and Restaurants	51	33	32	52	473	153	96	530
Personal Services, Recreation	99	47	42	104	416	189	115	490
Sub-total	150	80	74	156	889	342	211	1,020
Administration and Professional								
Hospitals	158	31	27	162	1,675	403	497	1,581
Medical and hygenic services	36	6	7	35	10	6	1	15
Educational, professional etc.	51	21	11	61	228	49	67	210
Government services	512	152	57	607	446	16	26	436
Local Authorities	71	30	12	89	23	-	8	15
Sub-total	828	240	114	954	828	240	114	954
Other Services								
Sub-total	3	3	3	3	-	-	-	-
TERTIARY INDUSTRY TOTAL	4,703	1,102	791	5,014	4,276	1,061	1,094	4,243
TOTAL ALL INDUSTRIES	10,824	2,963	2,439	11,348	10,207	1,500	1,570	10,137

Data Source: *Monthly Review of Employment*, November 1948.

TABLE 7.5: Labour Shortages by Employment Districts

Employment Districts	Survey Vacancies per 1,000 Survey Employees* Males October 1955	Males October 1956	Females October 1955	Females October 1956
Auckland	32	19	52	36
Lower Hutt	96	65	55	40
Wellington	79	51	80	51
Christchurch	49	34	57	43
Dunedin	57	44	64	49
Sub Total: Urban Districts	52	35	61	43
Whangarei	35	29	37	22
Hamilton	51	33	41	41
Paeroa	22	20	27	22
Tauranga	32	24	23	27
Rotorua	44	24	50	35
Gisborne	40	36	30	27
Napier	55	43	34	40
Hastings	48	36	40	28
New Plymouth	36	34	19	20
Wanganui	56	42	43	35
Palmerston North	49	34	43	37
Masterton	51	48	54	52
Sub Total: Rest of North Is	46	33	38	33
Blenheim	44	38	38	31
Nelson	28	21	49	36
Westport	32	31	26	9
Greymouth	64	37	54	56
Ashburton	51	47	55	47
Timaru	37	28	32	26
Oamaru	48	42	29	32
Invercargill	67	58	56	43
Sub Total: Rest of South Is	50	40	46	38
NEW ZEALAND	50	35	53	40

* Excluding Seasonal Industries

Reproduced from *Labour and Employment Gazette*, 1957, 29

for all the urban centres while in the latter year it is considerably lower than in many of the non-urban areas for both males and females. As the *Labour and Employment Gazette* commented:

> The relative weak demand for males in Auckland district is reflected in the difficulties experienced in finding work there for unskilled males. The demand for female labour in Auckland is much stronger, though not as strong as in the other main centres (LEG, November 1957, 29).

The relative weakness in demand for labour in Auckland could account for the failure of contractors to gain a substantial foothold there. This is clearly at variance with the views expressed earlier by the secretary of the Auckland Hospital Board in 1948. Although the female vacancies per 1,000 of the labour force are not available for that year, the figure for males, according to the *Monthly Review of Employment*, was 19.4 per 1,000 which was below the national average of 21.0 per 1,000. Clearly the view of the Auckland Hospital Board was based on a subjective interpretation of the employment situation and in reality the labour shortage there was not as severe as in many other regions.

In the less urbanised areas, contracting out was slower to develop as can be seen from the maps for 1950 and 1960 in chapter six. It will also be recalled from the previous chapter that the coastal region from East Cape (Waiapu) to Wairarapa was the last part of the country to adopt contract ancillary services and three of the boards in this region (Waiapu, Cook, and Waipawa) have still not done so to this day. Significantly labour shortages appear not to have been so critical in some of these less populous areas and hence the pressure to bring in contractors was reduced. With the exception of Masterton (Wairarapa), which had a comparatively high level of job vacancies in 1956 (table 7.5), the other employment districts covering the eastern parts of the North Island (Gisborne, Napier and Hastings) each had lower job vacancies figures for males and females than the urban districts.

Although the coincidence between hospital board and (Department of Labour) employment district boundaries is far from from exact (figure 7.2), there are a sufficient number of similarities to permit a statistical comparison of contracting out with labour shortages. In table 7.6, data is given on male and female job vacancies (per 1,000) for October 1955 and 1956. The hospitals boards, whose districts closely approximate employment districts, are grouped according to those which, by 1960 at least, had commenced with contract service provision. It will be recalled from the previous chapter that the exact state of contracting out at any time between 1950 and 1960 is uncertain.

TABLE 7.6: Coincidence Between Hospital Board Districts, Labour Shortage and Contracting Out for 1955 and 1956

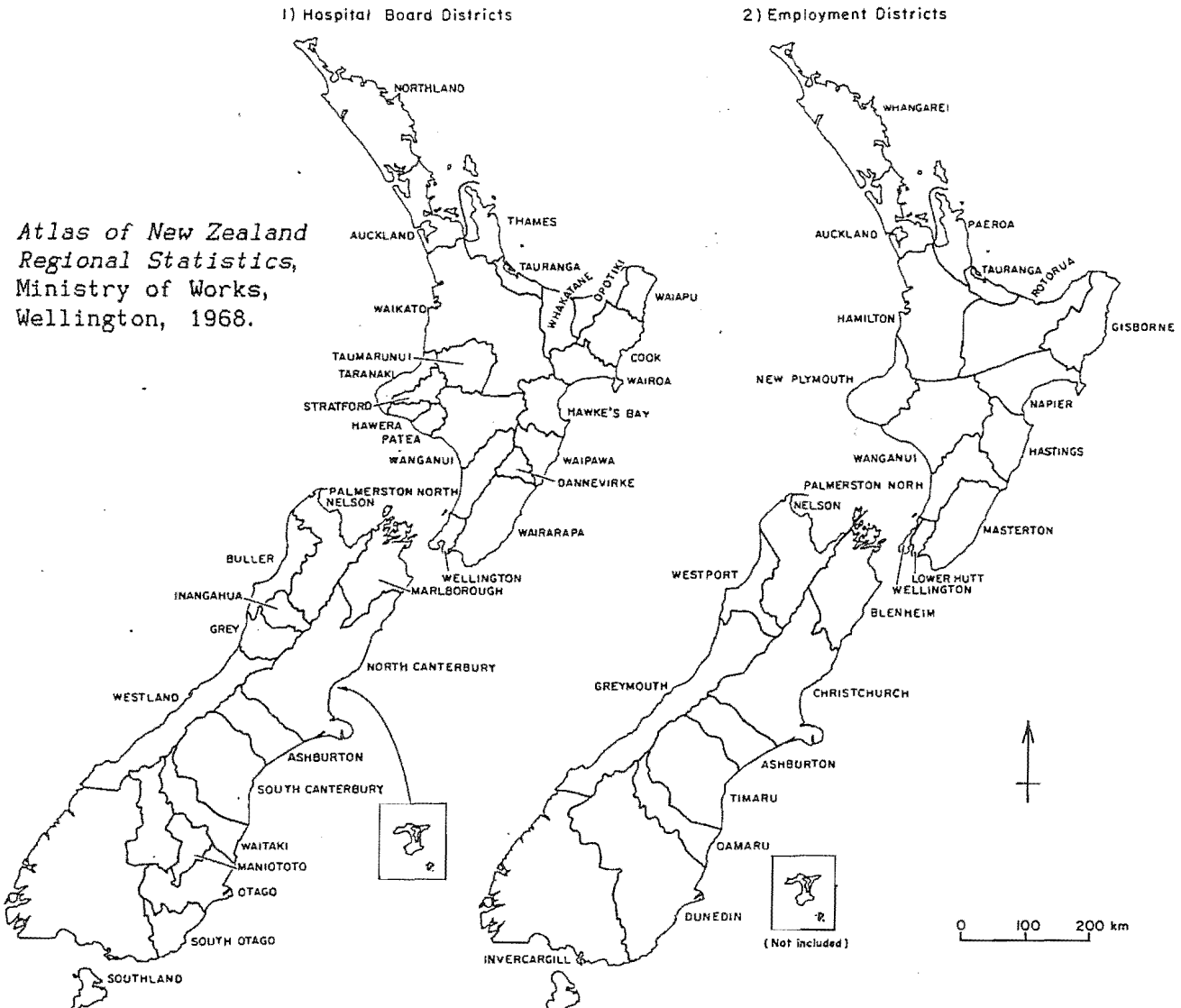
Hospital Board Districts	Employment Districts	Labour Shortages; Vacancies Per 1,000 1955 Male	1955 Female	1956 Male	1956 Female
		Contracting Out Boards			
Northland	Whangarei	35	37	29	22
Tauranga	Tauranga	32	23	24	27
Palmerston N. Dannevirke	Palmerston N.	49	43	34	37
Wellington	Wellington	79	57	51	51
	Lower Hutt	96	55	65	40
Marlborough	Blenheim	44	38	38	31
Canterbury	Christchurch	49	57	34	43
Ashburton	Ashburton	51	55	47	47
S. Canterbury	Timaru	37	32	28	26
Southland	Invercargill	67	56	58	43
TOTAL		539	453	408	367
Median		49	49	36	39
Mean		53.9	45.3	40.8	36.7
		Non-Contracting Boards			
Auckland	Auckland	32	52	19	36
Thames	Paeroa	22	27	20	22
Cook Waiapu	Gisborne	40	30	36	27
Wairarapa	Masterton	51	54	48	52
Nelson	Nelson	28	49	21	36
Waitaki	Oamaru	48	29	42	32
TOTAL		221	241	186	205
Median		36	40	29	34
Mean		36.8	40.2	31.0	34.2

The *t*-Test statistic = 1.845 for males for 1955
= 0.789 for females for 1955
= 1.417 for males for 1956
= 0.486 for females for 1956

For 14 degrees of freedom the critical 5 percent and 1 percent values are 1.761 and 2.624 respectively. Consequently only for males for 1955 is the difference between group means significant and only at 5 percent.

Source: compiled from data in *Labour and Employment Gazette* 1957, 29

Figure 7.2 Comparison of Hospital Board and Employment District Boundaries for 1950



Source: *Atlas of New Zealand Regional Statistics*, Ministry of Works, Wellington, 1968.

As table 7.6 shows, mean and median values for the contracting boards are consistently higher than for non-contracting groups of boards. With the job vacancy data given in rates per 1,000 (of surveyed employees), the group arithmetic mean is not strictly valid but the absence of raw data precludes the calculating of more precise mean values. Notwithstanding this limitation a *t*-test was conducted between the means of the two groups for 1955 and 1956 for both males and females. This revealed that there is no significant difference between them except for males for 1955 and then only at the five percent level. This would indicate that factors other than labour shortages may also have been mediating the uneven development of this form of privatisation.

7.4.2 Institutional Factors:

The major limitation with using regional variations in job vacancies as the sole explanatory variable for spatially uneven contracting out is that the labour shortage was still ubiquitous throughout the country even if not uniform within it. Nowhere seems to have had a surfeit of labour which would, potentially at least, have given hospitals a ready supply of workers. Another factor which seems to have had a retarding influence on the development of contracting out in the less urbanised areas relates to the internal organisation of the boards themselves. As the previous chapter showed, the boards covering rural areas tended to be much smaller in terms of population served and bed numbers, than those in the main urban areas. The relevance of institutional size here relates to its effect on the division of labour and degree of job specialisation likely to occur.

The comments of the Secretary at Dannevirke Hospital Board in 1948 illustrate this point. When previously employed at the North Canterbury Hospital Board he strongly recommended the adoption of contracting out at Christchurch Hospital. At Dannevirke, although the possibility of contracting out domestic cleaning services still existed owing to acute staff shortages, there were not, he maintained, the same grounds for recommending its adoption as in Christchurch, "*by virtue of* [the hospital's] *much smaller size and consequent inter-relation of many duties other than purely domestic ones by members of the staff involved*" (WHB 1948, 10). According to records it was not until 1958 that the Board finally contracted out its services although no indication was provided as to why such a decision was finally made.

The Nelson Hospital Board presented a similar argument even though the population of the board's district was over 37,000 in 1950. But as the hospital itself was very small for a district of this size, having only 186 beds in 1950, the argument of the effects of institutional size could

still hold. The Board secretary is reported as having said in 1948 that if contractors were to be involved in providing domestic services it would necessitate, "*the complete revision of many sections of the staff where dual or several services had previously been performed by individuals*" (WHB 1948, 10). Waipawa, which was around the same size as the Nelson Board, cited similar reasons for declining to contract out. The Board Secretary maintained that, "*similar difficulties in regard to persons carrying out dual or several services have been forseen and for which the only remedies will add considerably to our costs*" (WHB 1948, 11).

The essential point being expressed by these boards was that contracting out would entail less flexibility in the control of the work force. Contractors would only perform according to what was specified in the contract, which might not always conform with the actual requirements at the time. By this interchangeability of staff, smaller hospital boards may have been able to achieve a greater degree of labour productivity than larger boards from their existing staff and thereby reduce the pressure to engage contractors. In this way some of them managed to provide their own services into the 1960s and later while a few have never contracted out at all.

The question that arises then is, what factors in the end precipitated these smaller boards into contracting out their services? Some of the comments of the former Chief Executive of the Vincent Hospital Board are instructive in this matter:

> In small institutions such as Cromwell and Dunstan Hospitals, the person responsible for the hiring, firing, organising and supervision of household/dietary staff was "the Matron". She had this task in addition to her responsibilities to supply an adequate nursing service. All this put an extremely heavy burden on the Matron (in those days always a female), and her free time was almost non-existant....So therefore the basic reason to contract out the household/dietary services was to free senior nursing staff from work they were not trained for and to leave them free to carry on with the work they knew best - nursing (written personnal communication 25th May 1989).

The reduced division of labour in smaller boards only seems to have delayed, rather than permanently prevented, the implementation of contract service provision. Problems of work force management brought about by labour shortages finally made these boards succumb to the contract option.

A further factor that seems to have precipitated contracting out was the role model of the larger boards. Their general satisfaction with contract provision and the existence of written correspondence between boards suggest that the idea of contracting out expanded through a diffusion like process from the larger to the smaller boards. Regrettably

records are too incomplete to detail the process in a comprehensive way but, whatever its extent, the underlying basis for contracting out remained the overall labour shortage generated by national economic development.

7.4.3 Political Factors

Throughout most of the time since the end of World War Two, and for the duration of the period in which contracting out developed, the government in New Zealand was formed by the National (conservative) Party. Although this party had a strong committment to the growth of private enterprise and might therefore have been thought to have encouraged the process of contracting out to the private sector, little evidence exists to support this contention. Ironically the earliest development of contracting out occurred in the period immediately after World War Two when a Labour Government was in office. Labour, with its strong commitment to comprehensive public provision of services, was in power from 1945 until 1949 during which time several hospital boards contracted out at least some of their ancillary services.

During the periods of National Government, which existed from 1949 to 1957 and then from 1960 to 1972, considerable emphasis was placed on the encouragement of private hospitals in particular and private enterprise in general. This is illustrated by some of the parliamentary speeches of the time as cited in *Hansard*. For example, in 1950 the member for Tauranga argued that:

> It is a very serious thing for this country that so many private hospitals and maternity homes have gone out of existence during recent years (*Hansard* 1950, 874).

A few years later the member for Palmerston North maintained that:

> Private Hospitals should be encouraged, first because they reduce the number of beds required in public hospitals and therefore the capital cost to the Government and secondly because they provided a service for the class of person who preferred a private room and the choice of his own doctor and was prepared to pay more for these privileges.... The cost per bed in a private hospital would be much less than in a public hospital and encouraging people to go into private hospitals would save the Government a great deal of expense (*Hansard* 1953, 2257)

while in 1954, according to the Minister of Health:

> The present Government believes that private hospitals perform a valuable function in supplementing the services performed by public hospitals and since we have been the Government we have given considerable encouragement to private hospitals to continue their work and in some cases expand their activities (*Hansard* 1954, 376).

The enthusiasm for private hospitals did not it seems extend to the private contracting of public hospital services. Perhaps in view of the

economic circumstances under which contracting out took place this observation is not so surprising. The process invariably resulted in greater financial costs to the boards than if they had provided the services themselves. Contracting out then hardly appeared to be a matter of economic expediency in which claims might be lodged for the greater 'efficiency' of private enterprise even if, as was sometimes claimed, the contractors made a more efficient use of labour. Unlike the case of private hospitals, contracting out ancillary services could not, in this period at least, be seen as a way of reducing government expenditure on hospital services.

The bureaucratic arm of government, in the form of the Department of Health, was aware nonetheless that where contracting out was resorted to then it should be by periodic competitive tender. The provisions of the 1956 Hospitals Act which the Department had to administer were such that hospital boards could not let contracts for terms greater than three years without prior consent from the Minister of Health. The Department has also required, or at least recommended, that competitive tenders should be called if only to minimise the cost of contracting out. Much of the available evidence however suggests that this requirement was often observed in the breach. According to the secretary of the Marlborough Hospital Board in a letter of 9th June 1969 to the Wairarapa Hospital Board:

> The Board could not agree that the [Department's] recommendation [for contracting out by competitive tendering] is as good in practice as it might seem in theory and consequently decided that it would change the basis of the contract with Crothalls and also review it annually.... The Department of Health still contends that it is desirable to call tenders for contracts of this nature but the Board is not prepared to agree with them.

Whatever the views and requirements of the central government on contracting out for services they seemed to have had very little control over hospital board policy decisions in these matters.

In respect of the regionally uneven development of contracting out, no evidence was found at the individual board level to indicate any correspondence with the political affiliations of board members. The main difficulty with citing the political factor at the regional level as an explanatory variable for uneven privatisation is that hospital boards have generally not been elected along party political lines, contra national parliament and local government elections. In the context considered here there has not then been any neat Labour/National divide between the boards to compare with any particular spatial pattern of contracting out.

Indeed hospital board elections could be compared with the so-called

'reform movement' in US local administration and their advocation of 'non-partisan' elections. "*The ethos of the reform movement*", according to Johnston (1979, 51), "*was anti-partisan and in favour of 'good' government for all*", notwithstanding the claim that, "*Reform was an upper middle class movement and its successes were in the conservative, small suburban municipalities* [in the USA and Canada]" (Johnston 1979, 51). This matter will be discussed further in the following chapter but as regards the New Zealand hospital boards, but it is worth noting that board members claimed to represent the community as a whole rather than a sectional or class interest. Furthermore, even if any regional variations in the political composition of board members had been discernable, it might have borne little relationship to the spatial pattern of contracting out in view of the generally greater financial cost that this policy entailed compared with board provision.

Conclusion:

This chapter has shown how private contracting for the provision of public hospital ancillary services developed primarily as a consequence of the post World War Two boom in the national economy which entailed an associated high demand for labour in both manufacturing and service industries. Changing conditions within the hospital boards were also significant features in establishing the need for ancillary workers as the nursing profession sought to eliminate what were becoming considered to be non-nursing duties. By contracting out certain ancillary services boards were able to divest themselves of the problems of workforce recruitment.

Explaining the geographically uneven development of contract provided services is somewhat more problematic, primarily because the data is very fragmentary. Nevertheless regional variations in the labour market, as measured by job vacancies, go some way to explaining why the initial development of contracting out occurred largely, although not exclusively, within the boards centred on major urban areas. The boards based on less urbanised districts, not only seemed to suffer less from labour shortages, but because of their smaller size could make more effective use of the labour they possessed and so obviate the immediate need for contractors.

Two main reasons appear to have been responsible for finally persuading the smaller boards into private contracting. First was the persistence of managerial responsibility for ancillary workers being shouldered by nursing administration and second was the generally satisfactory experience of large boards with contract services. In summary it may be said that the geography of contracting out public hospital ancillary services in the 1950s and 1960s was largely a product of

industrial expansion and variations in the organisational characteristics of the different boards.

The remaining issue is to set the explanations in terms of the broad theoretical frameworks established in chapters two and three. A degree of reluctance on the part of board management to privatisation has been evident as public choice theory would suggest, although no evidence was found for the uneven development of contracting out to be a reflection of electoral political processes. In view of public sector bureaucrats' alleged maximisation tendencies their seeming reluctance to contract out services appears consistent with the theory. On closer inspection however the maximisation thesis is difficult to sustain since during the period under consideration, contracting out was not a matter of economic expediency. State (hospital board) provision was generally more economical but administratively much more difficult. As contracting out occurred primarily on account of acute labour shortages throughout the country the process may most appropriately be set within terms of Weberian 'bureaucratic rationalisation'; it eased the administrative burden of hospital managers.

As the existence of these labour shortages was contingent upon the rapid growth of the economy or, in other words, capitalist development, then any comprehensive explanation of this privatisation cannot be divorced from the macro-social context. Constant efforts were made throughout the early period to raise the productivity of labour in order to overcome the labour shortage and it was often thought that contractors could do this more effectively that could the hospital boards themselves. Within a Marxian perspective, contracting out, when set in terms of the balance of class forces, presents itself as a device to maximise the productivity (exploitation) of the existing, but numerically insufficient, labour force.

The geographically uneven development of contracting out is perhaps best explained in terms of regional variations in the structure of bureaucracies or more specifically the hospital boards. But taken in isolation from the broader socio-economic context this only provides a superficial explanation of the process. The underlying social basis of contracting out must be based within the framework of enhanced national capital accumulation. Perhaps the most significant theoretical conclusion to be drawn from the empirical study undertaken in this chapter is that privatisation by contracting out, in as much as it is a means to increase labour productivity and/or shed managerial responsibility, is just as much indicated in times of economic expansion as in times of economic recession. It is to study the process under these latter conditions that is the

subject of the following chapter.

Footnotes:

1 Waipawa Hospital Board became the Central Hawkes Bay Hospital Board in 1986.

2 Plunket, known officially as the Royal New Zealand Society for the Health of Women and Children was formed in 1907, with the purpose being to disseminate scientific methods of feeding and training children so that, in the words of the founder Truby King, "*the main supplies of population for our asylums hospitals, benevolent institutions, goals, and slums would be cut off at sources*" (King 1913, 151 cited in Olssen 1981, 259).

3 North Canterbury Hospital Board became the Canterbury Hospital Board in 1983.

4 Morrison (1989, 53) argues that over the 1981-1988 period, 'notified' vacancies in New Zealand accounted for only about half of all advertised vacancies. The level of under enumeration of notified vacancies for the 1950s has not been possible to ascertain.

5 According to the Labour and Employment Gazette (February 1957, 20), 'surveyed' vacancy data, "*includes working proprietors and full-time employees but excludes one-man businesses, own account workers, part-time employees and farming, fishing, hunting, waterfront and seagoing personnel, household domestic service and armed forces*".

CHAPTER 8

Contemporary Developments in the Contracting Out Of Public Hospital Ancillary Services

Three distinct phases have been identified in the historical development of contracting out public hospital ancillary services. The first was marked by, a progressive development in contracting out which lasted until around the late 1960s and this was followed by a phase in which there was a period of virtual stagnation in the process. In the third phase, beginning in the late 1970s and lasting to at least the mid 1980s, there were many changes by the hospital boards to their ancillary service provision. This occurred even though the total aggregate index of privatisation remained fairly constant from 1975 to 1989 as judged by the quantifiable terms used in chapter six.

The previous chapter discussed the geographical development of contracting out in the earliest phase while the prime purpose of this, and the subsequent, chapter is to analyse the process in the two more recent phases. In discussing the early development of contracting out, it was seen that the process could only be explained with reference to the growth of the national economy and its associated 'problem' of labour shortages. As the contracting out process assumed a very different developmental form in the two subsequent phases identified, but particularly the third one, it is important to consider the changes that have taken place in the socio-economic environment of New Zealand since the late 1960s and relate them to the observed changes in private contract provision. To present a comprehensive account of New Zealand's economic development over the last two decades is beyond the scope of this thesis but in the first section of this chapter, some of the most salient features are identified.

The second section discusses changes that have occurred over the last two decades in the financing of hospital boards by central government. Together with the changed socio-economic conditions, the increasing financial constraints on hospital boards provides the context for attempts to explain the geographical development of contracting out of hospital ancillary services since around 1970. Using the theoretical frameworks upon which this thesis is based, the subsequent three sections are devoted to attempts to explain the sectoral, spatial and temporal development of private provision in a period of general economic recession. A sixth section looks at how changes to the political composition of national and regional authorities may also have had an impact on the uneven growth of private sector provision. In the final section of the chapter the relevance of certain managerial (bureaucratic) processes to the development

of contracting out in the 1970s are examined for their explanatory potential.

8.1 New Zealand's Economic Development since the late 1960s:

The late 1960s and early 1970s marked a watershed in the development of the New Zealand economy. For Gould (1982, 113) the period 1967-75 was the end of the "*golden weather*" that had existed since World War Two and "*the prosperous years of the early and mid sixties were brought to an end by a balance of payment crisis arising in large part from the downturn in growth rates in Western Europe and the UK*" (Gould 1982, 114). Marking the period 1967-68 was the first post war devaluation, a nil general wage order by the Arbitration Court, the highest unemployment rate since the Depression and the most rapid inflation since the Korean boom (Gould 1982, 115). Also at this time, although much less publicised, was the first restriction on the spending of hospital boards, a point that will be commented on further in the next section.

Economic historians whether Marxist (eg Steven 1985) or non-Marxist (eg Hawke 1985) maintain that, historically, economic (capitalist), development in New Zealand has been largely founded on receipts from trading agricultural produce (land rent) rather than on profitable investment in manufacturing industry (wage labour). The gradual decline in the international competitiveness of New Zealand agriculture from the late 1960s, provided a stimulus for the basis of national development to be redirected towards manufacturing industries in which profit would accrue from the productive employment of wage-labour rather than the receipt of rent (Steven 1985, 45). In particular export manufacturing, rather than import substituting, industry was seen as the way ahead. According to Hawke (1985, 326):

> the fastest growing component of the international economy during the 1960s was the international exchange of manufactured goods [but] New Zealand did not share that experience... and... with the devaluation of 1967, manufactured exports were seen as the vehicle for participation in world economic growth

The critical point for Steven (1985) is that this policy required a much higher than hitherto existing degree of labour productivity so that domestically produced goods could compete with foreign imports. In a highly regulated and protected economy, such as was New Zealand, wage rises, in general, could be conceded by employers if only because wages could simply be passed on in price rises as there was virtually no competitive market. The high value of agricultural exports in the world market was such that, up to the 1970s, both high wages, full employment, and an economy with low labour productivity could be sustained (Steven

1985, 45). This situation no longer held after the late sixties and consequently manufacturing was required, "*to stand on its own feet rather than to be an employment sponge and a means of utilising talents not catered for in farming*" (Hawke 1985, 326)

The crisis of the late 1960s was relieved in the early 1970s by a brief commodity boom but, in the words of Gould (1982, 123) "*the good old days of the early and mid sixities refused to return*", due largely to the persistence of inflation and deteriorating industrial relations. In respect of the latter, Gould comments that:

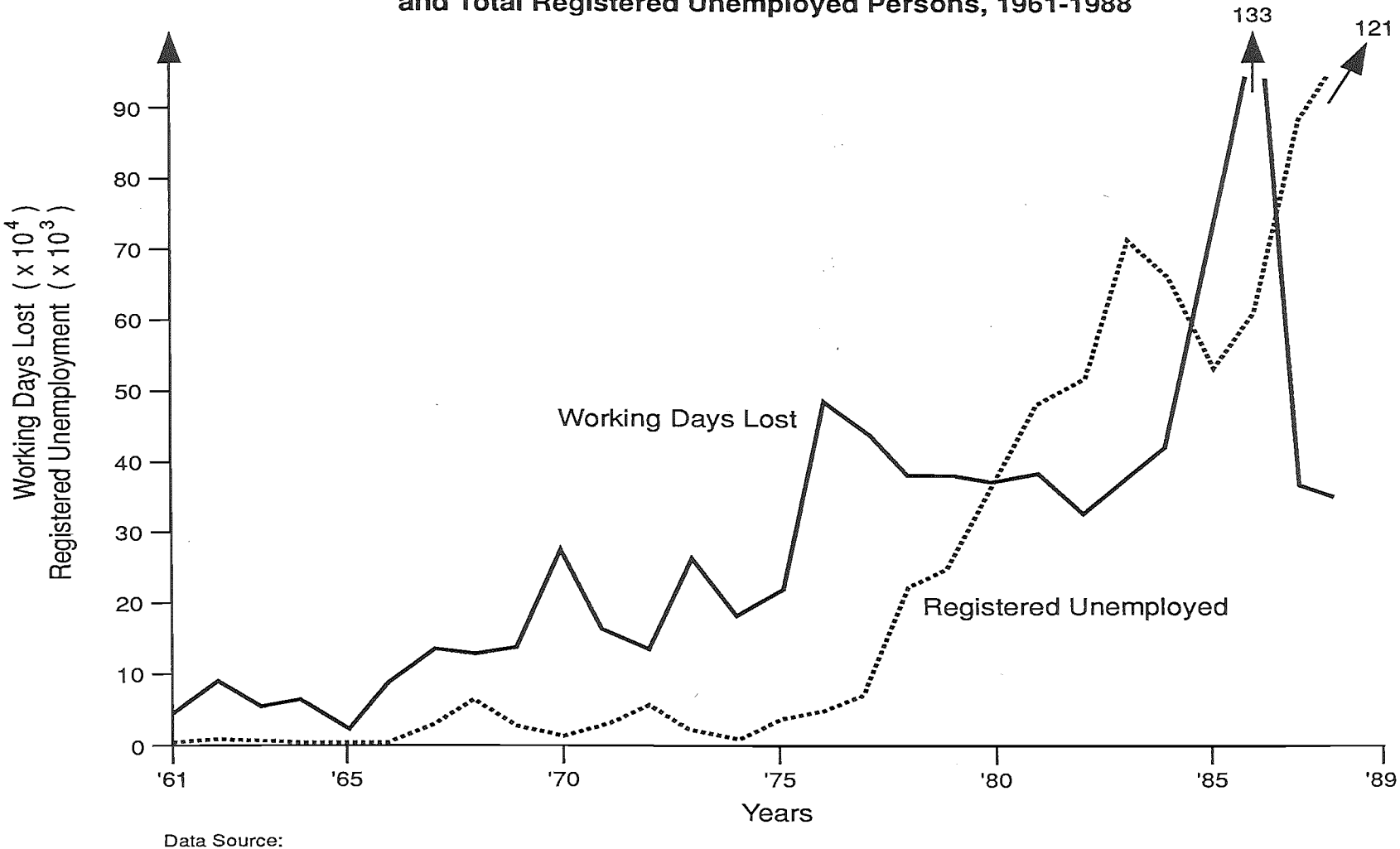
> Following the nil wage order of 1968 wage negotiations had moved definitively from the arena of the Court of Arbitration into that of direct bargaining, and unions which had hardly tested their muscle since the crushing defeat of 1951 quickly came to realise their strength. Big wage demands were made and conceded under the threat or reality of strike action; working days lost in industrial disputes were twice as numerous in 1970 as in 1968, when they were already at more than twice the average level of the mid 1960s (Gould 1982, 124).

From the late 1960s, but particularly from the mid 1970s there was a steady rise in both the numbers of registered unemployed and the levels of industrial (class) conflict as measured by working days lost through strike action (figure 8.1).

By the mid 1970s the commodity 'boom', which had sustained economic growth in the early seventies, had 'bust' and New Zealand's terms of trade fell "*continuously and catastrophically.... caused primarily by a massive increase in import prices of which the biggest component came of course from the first series of oil price 'hikes' by the OPEC countries...*" (Gould 192, 131). After a brief spell of Labour Government from 1972, a deteriorating economic situation and a general mood of political conservatism in the population at large ensured the election of a National Government from 1975 to 1984.

The need to induce higher levels of labour productivity in the workforce from the late 1960s required a variety of policies that have come to be known collectively as, industrial (capitalist) 'restructuring'. If by the term 'restructuring' is meant the exposing of New Zealand industry to international competition so that, "*the weaker capitalist enterprises could either become strong or be destroyed altogether*" (Gallagher and Swainson 1985, 22) then this policy could be said to have commenced with the 1975-1984 National Government. Some the major changes implemented during this time were the deregulation of transport and freezing works, taxation reform, some tariff reduction, as for example with Closer Economic Relations (CER) with Australia, state

Figure 8.1 Working Days Lost Through Industrial Stoppages and Total Registered Unemployed Persons, 1961-1988



Data Source:
New Zealand Official Year Book, various years
Key Statistics
Work Stoppages and Industrial Union Statistics

incentives to engage in new forms of agriculture such as horticulture, viticulture, and silviculture, and large energy producing projects designed to reduce dependence on imported fuels, typically the 'think big' projects (see Edlin 1984 and Terry 1984). According to Gallagher and Swainson (1985, 21) towards the end of the 1970s 'restructuring' became referred to as 'export led' growth, while in the early 1980s it was 'think big' and 'CER' shortly after. From the 1980s onwards, 'privatisation' has arguably been the predominant style of 'restructuring' taking the form of the corporatisation, commercialisation and sale of much of the state sector and the further deregulation of finance and commodity markets.

It was not only productive activity that started to be 'restructured' from the mid 1970s onwards as, according to Fougere (1984, 78), "*the breakdown of the Import Substitution Industry economy threatened the maintenance of Welfare State provision*". Export manufacturing required increased state expenditure to provide subsidies, which resulted in greater stress for Welfare provision, and has been vividly described by Consedine (1984). Indeed the whole Welfare State was beginning to show strains in the 1970s and the growing belief that it could no longer deliver all that was promised contributed in no small way to the increased political conservatism of New Zealand society as a whole. A major report by the New Zealand Planning Council in 1979 (NZPC 1979) pointed the need for a reassesment of its role while Maharey (1987, 78) claimed that:

> After 40 years of constant use the welfare state was beginning to collapse. People could not get into the public health system, they had to pay for their children's education, they were treated like criminals by the Social Welfare Department and made to feel like lay-a-bouts by the Labour Department. This was not the good society everyone hoped for.

During this early phase of industrial 'restructuring', significant changes were made by central government, to hospital board financing in order to reduce hospital costs. Not surprisingly the delivery of hospital ancillary services came to be subjected to ever greater financial pressure and major changes were made by many hospital boards to their contracting out policies in this area.

The financial pressure was indeed intensified rather than alleviated in the mid to late 1980s under the fourth Labour Government elected in 1984. This government pursued the previous National Administration's policies of deregulation much more vigorously and extensivly and, paradoxically for a Labour Government, followed a monetarist approach to economic management. If levels of unemployment are taken as a general proxy for the level of economic activity, it is seen from figure 8.1 that

depressed conditions existed in New Zealand well into the late 1980s.

At risk of oversimplification, economic conditions in New Zealand have been based on expansion to the late 1960s, followed by almost a decade of instability to the late 1970s and depression throughout the 1980s. All this coincides closely with the three different phases of contracting out hospital services identified earlier in the thesis. However it must be emphasised immediately that changing macro-economic conditions such as have just been described cannot be used in any deterministic way to explain the development of privatised ancillary service provision. For as the previous two chapters have shown, contracting out hospital services can occur just as much in times of expansion as recession. The theoretical linkage then between economic growth, or in Marxian terms, capital accumulation, and privatisation is both complex and contradictory. In the next section the changes made by Government to hospital boards' funding are examined in the context of the above developments.

8.2 The Financing of the New Zealand Public Hospital System:

It was seen in chapter five that in 1958 New Zealand public hospitals became entirely centrally funded from government taxation while being regionally administered. This basic system has remained to the present but it has undergone a series of changes since the 1950s. Initially the government made annual grants according to each board's own expenditure estimates. Problems with boards exceeding these grants and the steady rise in health care expenditure stimulated the government in 1968 to change the method by which funding took place.

In the Hospital's Amendment Act of that year hospital boards had to work within allocations fixed by Government rather than by themselves and this seems to have been the first legislative measure taken to contain hospital costs. But costs of hospital provision continued to rise and by the late 1970s the growing pressure on the Welfare State mentioned above stimulated the Government to make further restrictions in the overall financial allocations to boards. All boards were required to accept a one percent reduction in their allocation of funds in 1979-80, 1980-81 and again in 1981-82 (NZOYB 1984, 174).

Immediately following these one percent reductions, an attempt was made, not so much to reduce allocations *per se*, but to alter their distribution amongst boards so as to achieve a more effective utilisation of resources. The system that existed since 1968 was seen to have perpetuated the historical pattern of expenditure over the years without forcing any review of services by boards or their justification in times of change. The existing system of allocation was deemed to be inequitable.

Barnett *et al* (1980) reported on the wide variation of services provided between the boards, principally on account of their enormous size difference, and maintained that, "*it would be impractical, as well as financially irresponsible, to provide a wide range of medical services in each board area*" (Barnett *et al* 1980, 252). Patients requiring specialist treatment only available in a few centres would have to travel away from their own hospital district and so the expense of their treatment is born by the board to which they travelled. Also these boards would have had to maintain specialised equipment and staff plus provide teaching and research facilities all of which added to their financial burden (Barnett *et al* 1980, 252).

In trying to overcome these inequities, a 'population based' funding formula was applied to each board, starting in 1982, and founded upon similar lines to the Resource Allocation Working Party (RAWP) implemented in Britain in 1976. Instead of allocating according to previous year's increments, each board would have its annual grant assessed on the basis of changing needs where need was calculated on series of largely demographic characteristics of the board's population. Under this scheme some boards were identified as being over funded and some as underfunded against a 'norm' and by cutting some board's allocation and increasing others within the overall allocation the objective was to move all boards to 'equity' (Barnett 1984, 986).

In practice however this goal of equity proved difficult to achieve partly in view of the problematic nature of determining what equity is and partly through trying to implement the enormous redistribution that would be required to achieve it. Moreover hospital costs have continued to rise and boards, especially those covering the major urban centres, have experienced increasing difficulty keeping within their maintenance allocations. Consequently this method of funding for hospitals is being reviewed and at the time of writing the position in respect of future arrangements is unclear.

Perhaps the most critical point to emerge from the above two sections is that the changes in hospital board funding from 1979 coincided with rising hospital care costs and deteriorating macro-economic conditions and growing political conservatism. Both these factors placed the welfare sector of the state apparatus under considerable fiscal pressure. It is therefore necessary to see how hospital boards responded to the changed fiscal conditions compared with the 1950s and 1960s in respect of the provision of their ancillary services. For if the origins of contracting out these services was contingent upon national and regional labour

shortages, clearly a very different rationale for the process must have existed in the late 1970s and throughout the 1980s. These issues are addressed in the following sections.

8.3 Changes to Hospital Boards' Contracting Out Policies: Theoretical Considerations:

In terms of theoretical explanations of privatisation, the public choice framework argues that state sector managers will not privatise service provision unless required to do so by economic and political pressures. Only by contracting out to introduce market forces into the state sector, will bureau budgets be trimmed to a level consistent with what public choice theorists see as the 'public interest'. The Weberian perspective on the other hand sees managers themselves promoting privatisation policies to relieve themselves of managerial responsibility. This situation is deemed to hold particularly where the workforce is militant or generally 'troublesome' so the underlying rationale for privatisation may be covertly political rather than, or as well as, overtly economic. Finally the Marxian perspective, like public choice theory, sees privatisation as being a deliberate policy to reinforce the law of value, but unlike the latter, sees the implementation of the process as hinging critically upon the balance of class forces extant at any given time, place or industry.

It is, therefore, largely within the terms of public choice theory that the development of privatised service provision might be expected to be a direct reflection on the variations across time and space in economic and political constraints on state sector service provision. In the following sections the intention is to see how hospital boards' contracting out policies have changed in the seventies and eighties due to both increasing financial constraints on hospital boards, and changes in the political preferences of power brokers within these bureaucracies. The financial factors are considered first and following the analytical methodology developed in chapter six, they are discussed in relation to the sectoral, temporal and spatial dimensions of the development of private contracting. To start with however it is instructive to see how, in terms of cost structures, ancillary services have been affected, since the mid 1970s, vis a vis other hospital services.

8.4 Comparative Cost Reductions to Hospital Services:

Central governments have, since 1968 at least, always specified the total funding for each board, but it has been left to each boards' management, albeit with the approval of the elected members, to decide how the total allocation should be divided between the different services

provided. The only source of data available for making sectoral comparisons between hospital services is *Hospital Management Data* available from 1975 to 1988. Table 8.1 shows a division of total hospital costs between six different services, one of which is the ancillary sector and all of which exclude major capital expenditure.

An intersectoral comparative measure of rising hospital costs over the 1975-1988 period can be gained from the data in table 8.1 which is illustrated graphically in figure 8.2. The time span considered is divided into approximately two halves - 1975-81 and 1981-88 and all costs have been reduced, respectively, to 1975 and 1981 values using the average annual Consumer Price Index. This division in time span is made in view of the many changes to hospital boards contracting out policies that occurred around 1981 in that some boards went out to contract while others reverted to in-house provision. The means of hospital board funding also changed around this time with the advent of the population based formula.

In column (7) of table 8.1 it is seen that total hospital costs, have risen in real terms in both time periods. It is particularly noteworthy that the housekeeping sector, where most contracting out has occurred, has undergone the most significant reductions in the 1981-88 period, compared with all other services even those within the ancillary sector. Taking the ancillary services as a whole, they have shown still greater reductions than other services for this period. The situation is not quite so clear cut in the earlier period, but with the exception of diagnostic services, housekeeping shows the lowest increase of all services.

There are two important points to make here. The first is that no claim is being made that ancillary services have been the only ones to have had to sustain financial cutbacks. On the contrary records show that virtually all sectors had to make certain savings even if their costs in real terms have risen. The second point is that the most stringent reductions, especially in the 1980s, have come in the ancillary sector, especially housekeeping.

In terms of theoretical frameworks, a public choice explanation for this sectoral variation in cost reductions would be based on the relative political lobbying strengths of the respective sectional interests. To the extent that this was the case, it will be recalled from chapters five and six that heads of housekeeping services do not have the same access to senior board managment as do heads of other services. There is not therefore a similar administrative structure between the different sectors in which participants could have an equal platform upon which to lobby for funds as is assumed in the pluralist variant of public choice theory.

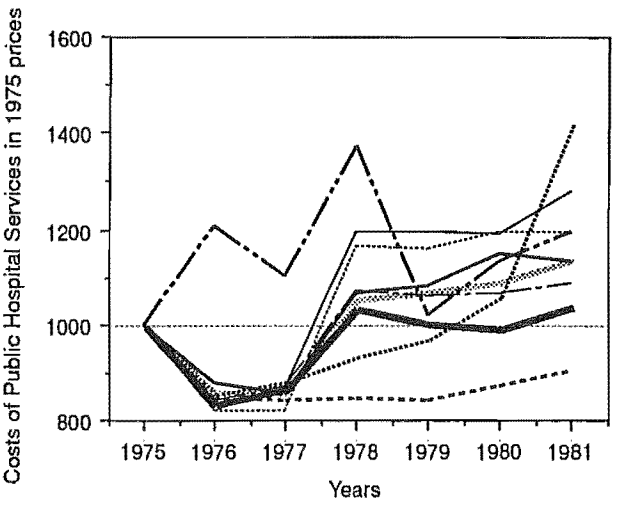
TABLE 8.1: Costs of Public Hospital Services in New Zealand 1975-1988 (in NZ$10,000s)

	(1) General Treatment Services	(2) Diagnostic Services	(3) Hotel (Ancillary) Services			(4) Engineering/Maintenance	(5) Administration Services	(6) Community Services	(7) All Hospital Services (Total)
			Housekeeping	Laundry	Dietary				
1975	11966 1000	1690 1000	2499 1000	460 1000	1567 1000	1818 1000	3066 1000	585 1000	23651 1000
1976	15447 878	2109 849	3064 834	568 840	1853 821	2198 822	3626 1206	736 856	29603 862
1977	17590 856	2438 840	3682 867	688 871	2182 821	2707 867	4553 1101	890 885	34731 865
1978	25097 1068	2812 847	5078 1035	968 1071	3588 1166	4276 1198	6135 1374	1096 937	49049 1057
1979	28451 1081	3127 842	5471 1004	1071 1060	3999 1162	4793 1199	7664 1019	1271 971	55613 1071
1980	33387 1152	3683 871	6207 993	1226 1066	4682 1195	5418 1192	8441 1136	1577 1059	64606 1093
1981	39864 1137	4480 905	7635 1043	1463 1086	5500 1199	6810 1279	10825 1195	2480 1422	79056 1142
1981	39864 1000	4480 1000	7635 1000	1463 1000	5500 1000	6810 1000	10825 1000	2480 1000	79056 1000
1982	49441 1075	5931 1147	9136 1037	1776 1052	6881 1084	8261 1051	11848 949	3057 1068	96330 1055
1983	61874 1582	6611 1101	9842 962	2057 1049	7584 1029	9517 1043	15053 1038	3682 1108	116134 1096
1984	65210 1369	7033 1091	9320 851	2205 1047	7799 887	9361 956	12919 829	4729 1325	118698 1041
1985	67577 1110	7494 1096	9847 848	2055 920	8017 955	9610 925	13793 833	5170 1365	123653 1023
1986	78161 1112	8189 1037	11071 825	2317 898	9098 938	11137 928	17934 940	6496 1486	145403 1041
1987	103602 1302	11270 1261	13007 856	2835 971	10421 949	13180 970	22421 1037	8570 1731	185789 1175
1988	117108 1272	12965 1253	14811 840	2820 844	11124 885	14243 906	28711 1148	10984 1918	212736 1163

The right hand figures in each column have been adjusted for inflation by reducing all prices between 1975 and 1981 to 1975 levels and between 1981 and 1988 to 1981 levels, using annual average Consumer Price Index.
Owing to rounding errors, costs of services may not add up to total costs.
Data Source: *Hospital Management Data & New Zealand Official Yearbook*, various years.

Figure 8.2 Costs of Public Hospital Services in New Zealand, 1975-1988

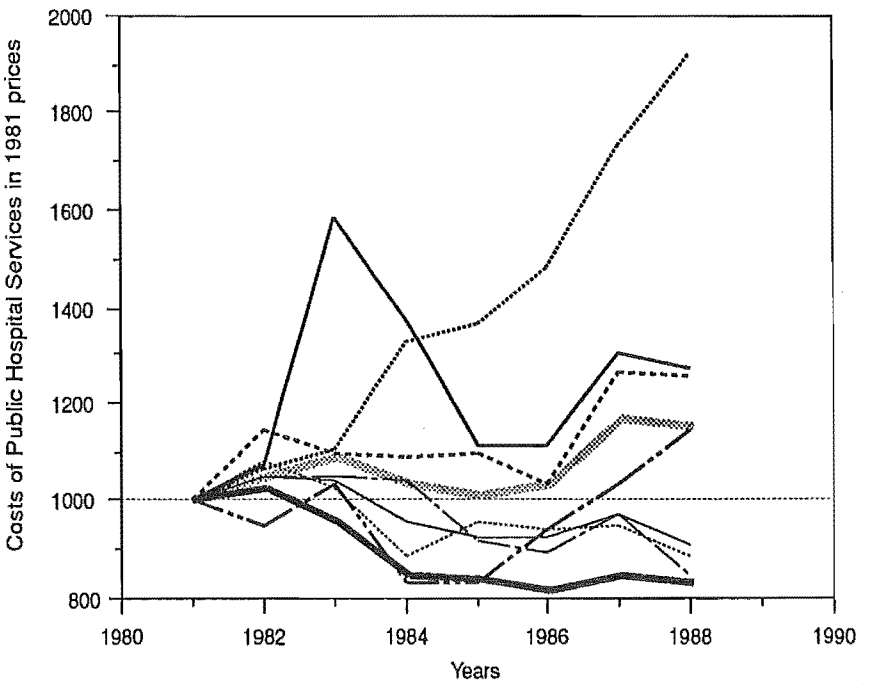
1) 1975-1981 (1975=1000)



Key to Costs of Hospital Services

- General Treatment
- Diagnostic
- Housekeeping
- Laundry
- Dietary
- Engineering / Maintenance
- Administration
- Community
- All Hospital Services

2) 1981-1988 (1981=1000)



Data Source: *Hospital Management Data* and *New Zealand Official Yearbook*, Various years

Moreover, as already seen in a previous chapter, taking ancillary services *in toto*, the workforce does not possess relevant professional or trade qualifications as exhibited in other sectors and this factor no doubt serves to advance the political power of these other sectors within the bureaucracy. The sectoral variation in cost reductions, particularly as they relate to ancillary services, is perhaps more plausibly explained in terms of a Weberian framework based on differing power structures between services rather than political lobbying.

This account of sectoral differences in costs of service provision still leaves open questions relating to how contracting out in the ancillary sectors has affected the costs of service provision. The following section examines, in a spatial and temporal context, the contention that hospital boards' contracting out policies have changed in accordance with changes to central government funding.

8.5 Contracting Out and Financial Restrictions

This section is considered in two parts. The first looks at the contradictory nature of much of the evidence for citing contracting out as the source of cost savings while the second attempts to analyse the contracting out policies in terms of spatial variations in financial constraints on hospital boards.

8.5.1 Contracting Out and Cost Savings: The Evidence:

After the changed method of funding introduced in 1968 the provision of hospital ancillary services started to come under increasing financial pressure, although data on costs of provision is not available prior to 1975. Nevertheless remaining board records are supportive of this contention. In 1970, the Secretary (Chief Executive) of the Wairarapa Board reported that:

> Now that hospital boards are on fixed Government grants any economies effected will result in money becoming available for other purposes, particularly replacement of equipment and maintenance of buildings. Weekend work with time and half for Saturday and double time for Sundays is particularly expensive and any reduction of work on these days can result in substantial economies. For nurses' homes, some boards have cut out all weekend work and despite initial opposition, the result has proved adequate (internal memorandum, 3rd June 1970).

Also around this time the market for ancillary services was beginning to expand. For those boards which opted for competitive tendering, the increasing market competition could reduce costs of service provision although the results were not always to the boards' liking.

Many boards, though exactly how many it has not been possible to determine, maintained a policy of negotiating savings with the incumbent

contractor. Where competitive tendering had been resorted to, the Wairapapa Board's Secretary, cited above, remarked that:

> A number of hospital boards have called tenders, accepted the lowest price and then become involved in very serious difficulty with a new contractor due to inexperience, too low a tender price to provide a service, poor supervision, etc. Other boards have made an annual review of the contract and negotiated considerable savings by a critical assessment of every duty laid down in the task schedule (internal memorandum, 3rd June 1970).

Only a few years later, the Secretary of the Palmerston North Board in a letter of 3rd April 1974 to the Secretary of the West Coast Board stated that:

> ... the Vacuum [Cleaning Company] were extremely keen to obtain the contract for this Hospital (which is well over $100,000 pa) and that they reduced every cost to a minimum and this includes profit and thus have no margin to meet the exigencies of the service.

Economies were therefore being sought in these services in the early 1970s but it was not until some years later that major changes started to occur in contracting out arrangements. Although no direct reference has been found to the one percent overall cuts that started in 1979, it is significant that so many changes occurred from this time on. To continue using the Wairarapa and Palmerston North Boards as examples, in 1979 both these spatially contiguous boards decided to adopt in-house provision. Records for that year do not exist for Palmerston North (nor for Wanaganui which also terminated its contract services that same year), but for Wairarapa, the Secretary (different from 1970) reported to the Board members that:

> [to] dispense with outside contractors .... would save the Board between $25,000 and $50,000 pa but figures are difficult to set out with any degree of accuracy owing to the lack of information available on the actual wage costs paid out by Crothall Industries Ltd and the size of their profit (memorandum to Chairman and Members of Board, 11th September 1978).

It will be recalled from chapter six that Maniototo also found it financially advantageous to dispense with contract provision. Also shown in that chapter was that other boards having problems with contractors put their services out to competitive tender in order to reduce costs rather than revert to in-house provision.

Around the same time however, some boards which had hitherto provided their own services, decided to experiment with the contract option. For example, the Hawkes Bay Board decided to contract out its domestic cleaning services in 1980 on the basis that, "*cost comparisons show Crothalls' tender as being $391,292 pa lower than the Board's budgeted cost*" (memorandum to Board members, nd). Similarly the much smaller

Thames Board predicted savings of around $18,000 pa at Thames hospital alone by contracting out the domestic cleaning and orderly services (written communication from Crothalls Ltd to Board Chief Executive, 26th September 1979). Discussions with the Auckland, Otago and South Otago Boards also revealed cost savings as the rationale for contracting out but no figures were available. The significant point is that these boards adopted the opposite policy to Wairarapa, Palmerston North, Wanganui and Maniototo but for the same reason; cost savings.

In respect of attempts to achieve cost savings in ancillary service provision four policy options can be identified, not all of which are mutually exclusive; to cancel existing contracts; to contract out; to tender out existing contracts and; to reduce service specifications in existing contracts. In the first case savings could be made by eliminating the payout on contractors' profits and overhead expenses. The second case works on the assumption that the contractors' greater 'management expertise' would enable significant savings notwithstanding their required profit margins. In both the third and fourth cases cost reductions come from reduced contractors' profits and levels of service provision as well as retaining the managerial expertise. Faced with increasing financial constraints the hospital boards responded with attempts to reduce ancillary service costs by any one or more of the above methods. Viewed from a strictly temporal perspective it is clear that contracting out policies changed significantly with the advent of more constrained financial conditions.

The differences in response to these constraints by the various hospital boards is not easy to explain in terms of the theoretical frameworks of the thesis. It is not so much the adoption of contracting out that is theoretically problematic but rather the opposite policy of reverting to, or remaining with, in-house provision. The contract option is readily explained in terms of all three theories. For public choice theory there is the alleged greater economic efficiency of private provision while for organizational (managerialist) theory, the divestment of managerial problems associated with the need for cost savings makes contracting out attractive. Finally Marxian theory would see the need to increase the exploitation of the labour force as being the rationale behind adopting contract provision.

On the other hand the termination of contracting out or retention of in-house provision, particularly under conditions of financial constraint, clearly runs counter to the first two theories. Neither can the third theory - Marxian class conflict - be invoked as the time period in which

these changes in policy occurred preceded the advent of labour militancy and the workforce campaign against privatisation. This issue will be considered further in the following chapter but for the present suffice to note that two possible explanations exist in respect of hospital boards which did not adopt the contract option.

The first, although this is not to imply any degree of relative importance, relates more to managerial than strictly financial considerations. For those boards that ended contract provision, the staffing levels, as specified in the contracts, would probably have been regarded as optimal for the desired level of service provision. The main problem for these boards was that often the actual standard of service provided was inadequate in view of the costs involved. Although not ever conclusively proved, the major reason for this appears to have been that frequently fewer workers were employed by the contractors than the contract document specified.

By eliminating the contractor, the boards not only saved money on contract payments (profits and overheads) but simultaneously gained a better service by being able to ensure that the requisite number of staff were employed to provide the service. In other words the boards would make financial savings and gain a more cost effective service through having greater managerial control of the service. In cases where contractors had never been engaged it could be argued that boards' direct managerial control over the service ensured the optimal level of service provision and cost effectiveness to the extent that no further advantages would acrue by contracting out.

The second explanation for rejecting the contract option is perhaps more reconcilable with public choice than Weberian organisational theory, and certainly more straight forward. Arguably hospital boards that opted to provide their own services were less financially constrained than those which engaged contractors. The former group could therefore afford higher, and hence more costly, levels of service provision. So the greater the financial constraint the greater the propensity to contract out. The main point to be considered is that greater cost savings may have been possible in the 'contracting' than in the 'non-contracting' boards. Alternatively stated, prior to privatisation, the services of the former group were less cost effective than the latter. To take these arguments further a quantitative measure is required of cost effectiveness and financial constraints in order to make comparisions between hospital boards adopting opposite forms of service provision.

8.5.2 Financial Constraints, Cost Effectiveness and Contracting Out

The extent of financial constraint which a board is under will clearly depend upon both the amount of the funding in monetary terms and the level of services that have to be provided with the funds. This latter variable is not directly quantifiable but as a first approximation the size of hospital board district's population may be used as a surrogate for the level of services required. Obviously the greater the population the more services a board has to provide and hence the greater its costs. This, however, is exceedingly crude as many large urban based boards have to provide certain specialised services not available in smaller more peripherally located boards.

A slightly more refined measure of service requirments is to take the board population with adjustments for cross boundary flows. Using a formula devised by Barnett *et al* (1980) and detailed in appendix 3, this formula takes into account the people who travel specially to the boards having specialised facilities. A simple measure of financial constraint on a board, in terms of cost per capita, may then be taken as:

$$\frac{\text{Hospital Boards Operating Grants}}{\text{Hospital Boards District Population with Cross Boundary Adjustments}}$$

The cost effectiveness of ancillary services can be quantified by relating their cost to the size of the institution as measured by bed numbers. In short the greater the cost effectiveness, the lower the cost per bed. Instead of using total beds as the controlling variable, average occupied beds' is chosen as it excludes beds that may not be in use at any one time and so not demanding of the same level of ancillary services and therefore of costs. Cost effectiveness is then given by:

$$\frac{\text{Cost of Service Provision}}{\text{Average Occupied Beds}}$$

A more appropriate standardisation variable at least for cleaning and orderly (ie housekeeping) services, might be total floor area of all the institutions within each board but it has not been possible to collate such data. Another factor that could distort the standardisation of housekeeping costs is the age of the institutions as newer buildings tend to require less cleaning and orderly services than older ones. Apart from the enormous difficulty of ascertaining an 'age factor' for each board, the exercise is unlikely to be worthwhile as most boards contain institutions

with a variety of old and new buildings. Taken across all the boards this factor may to a certain extent be self cancelling.

Within any hospital, patients requiring specialised diets might inflate the costs of dietary provision and therefore distort the data. But as with the 'age factor', the 'specialisation factor' is equally likely to be self cancelling across the entire country as most individual boards provide a range of patient services. This argument might appear to contradict the observation made above that many people have to travel to boards outside their home areas for specialised treatment. However this factor is at least partly accounted for by giving the service costs per bed. More importantly though there is no indication that a specialised treatment necessitating travel requires more, or less, costly dietary services. In the case of housekeeping requirements (cleaning and orderlies) these may reasonably be expected to be similar across all boards regardless of the specialities of the constituent hospitals.

Aside from this there are two other unavoidable distortions in the data. The first arises from the lack of conceptual clarity applied to the term 'housekeeping' services. As chapter five showed, there is a degree of variation between boards in their method of classification. The second is that, as seen earlier in the thesis, most of the boards that contract out only do so at some and not all of their institutions. Consequently the data for cost effectiveness on the contracting boards may be highly distorted by the institutions within them that did not adopt contract provision. As published data on ancillary services is not disaggregated to the individual hospital level it has not been possible to make any allowance for this. In conclusion then it is stressed that all the data involved in this exercise must be treated with the utmost circumspection.

The hospital boards were grouped into two categories; those that adopted or retained contract provision for the 1980s and those that did not. Data was collated for the census years 1981 and 1986 and is presented in table 8.2. The former year is particularly significant as it was around this time that considerable change took place in the spatial development of contracting out but 1986 is also considered primarily in order to see how the two variables - financial constraint and cost effectiveness - have

TABLE 8.2: FINANCIAL CONSTRAINTS ON HOSPITAL BOARDS AND COST EFFECTIVENESS OF ANCILLARY SERVICES FOR 1981 and 1986

Hospital Boards	1981 Financial Constraint ($ per capita)	1981 Cost Effectiveness ($ per bed) Housekeeping	1981 Dietary	1986 Financial Constraint ($ per capita)	1986 Cost Effectiveness ($ per bed) Housekeeping	1986 Dietary
Commenced or Retained Contract Provision for Ancillary Services:						
Auckland	194.2	4,575	2,631	325.7	8,858	4,938
Canterbury	240.5	2,576	2,828	380.9	4,713	5,425
Otago	311.5	2,861	2,419	483.7	4,673	4,445
Waikato	240.2	3,267	3,516	375.2	4,588	5,441
Wellington	243.6	5,094	2,935	395.6	5,043	4,384
Hawkes Bay	203.9	4,093	2,611	360.1	6,698	4,662
Northland	222.9	3,879	2,701	347.5	4,675	4,545
S. Canterbury	211.7	2,865	1,750	370.4	4,955	3,593
Southland	206.6	4,628	2,178	336.8	7,272	5,223
Taranaki	231.3	4,990	2,517	365.9	5,690	4,370
Tauranga	168.4	4,559	2,457	290.0	8,178	4,988
West Coast	467.9	2,639	1,813	690.3	3,888	3,060
Ashburton	246.8	3,497	2,642	370.7	4,590	4,676
Bay of Plenty	221.0	5,868	3,131	358.2	8.147	4,305
Marlborough	242.9	4,297	2,114	373.5	5,516	3,647
S. Otago	241.6	3,623	2,711	377.1	6,264	5,167
Taumarunui	174.4	3,927	2,910	282.9	9.174	6,581
Thames	195.8	3,261	2,300	354.1	5,543	4,207
Vincent	236.4	3,719	2,699	322.6	5,582	4,124
Waitaki	228.4	3,648	1,839	379.9	4,843	3,731
MEAN	225.6	3,878	2,725	364.5	5,900	3,978
Terminated or Refrained from Contract Provision for Ancillary Services:						
Cook	268.2	4,580	4,213	435.8	7,732	7.151
Nelson	353.0	2,240	2,739	538.1	4,154	4,248
Palmerston N.	272.2	2,777	1,656	461.1	4,741	3,866
Wanganui	199.5	3,235	2,802	343.9	5,111	4,460
C. Hawkes Bay	487.1	3,182	1,735	797.7	6,557	3,492
Dannevirke[1]	243.4	4,351	1,868	372.8	5,872	3,615
Maniototo	219.8	4,297	1,455	351.6	3,761	4,205
Waiapu	216.9	4,774	5,397	336.4	7,055	8,530
Wairarapa	187.0	3,651	2,156	324.5	6,154	3,697
MEAN	265.8	2,953	2,260	439.1	5,140	4,281

Financial Constraint = Grant per Capita (with cross boundary adjustments)
Cost Effectiveness = Housekeeping and Dietary Costs per Ave Occ Bed.
1 Houskeeping services in Dannevirke were provided by contract until 1985 but the Board is included in the non-contracting group since the rationale for termination was very similar to the other boards.
Data Source: Department of Health records, and *Hospital Management Data.*

changed over a five year time period. Regrettably the census data required to calculate cross boundary flows was not provided in 1986. In order to provide a degree of refinement to the 1986 figures for financial constraint, the hospital board districts' populations were each adjusted according to the percentage changes required to be made to 1981 board population figures. While it is readily conceded that this does not provide an optimal data base, it is still an improvement upon using unadjusted population figures.

As was seen in an earlier section, during the 1980s a population based funding formula was applied to the hospital boards. Whatever the effect of financial constraint on a board's propensity to contract out this cannot be adduced directly from the formula since its effects may be quite ambiguous. Whether under or over funded according to the formula, all boards experienced a degree of financial constraint and might therefore be tempted to contract out their services. The population based funding concept is therefore of little analytical value in itself. Nevertheless the 1986 figures for grant per capita (financial constraint) reflect the application of the formula to different boards.

The data given in table 8.2 is summarised in table 8.3. Starting with the mean grant per capita, this variable was lower (ie greater financial constraint), for the contracting boards than for the non-contracting ones. This was to be expected although *t*-Tests* showed the differences in group means to be statistically significant only in 1986 at five percent. Not so expected however was that cost effectiveness, in 1981, for both housekeeping and dietary services, showed lower costs per average occupied bed for non-contracting as against contracting boards. Here the differences in group means was only significant, albeit at 1 percent, for housekeeping services.

By 1986 the differences in cost effectiveness between the two groups had narrowed to the extent that *t*-Tests revealed no significance between them. In the case of dietary services, the position had reversed from 1981, even if only slightly, with the contracting boards appearing to be more cost effective. As this group of boards would have been making cost savings for which there was arguably less scope for in the non-contracting boards, the narrowing of differences over time is not particularly surprising. A rather more surprising feature is that, for the most part, the differences in mean values has been insignificant.

TABLE 8.3: Summary of Data and *t*-Tests for Contracting and Non-Contracting Hospital Boards for 1981 and 1986

	1981	1986
Mean Financial Constraints: (Operating Grant per Capita)		
Contracting Boards	$225.6	$364.5
Non Contracting Boards	$265.8	$439.1
t-Test statistics	1.36	1.71
Mean Cost Effectiveness for HOUSEKEEPING Services (Operating Costs per Bed)		
Contracting Boards	$3,878	$5,900
Non Contracting Boards	$2,953	$5,140
t-Test statistics	2.61	1.25
Mean Cost Effectiveness for DIETARY Services (Operating Costs per Bed)		
Contracting Boards	$2,725	$3,978
Non Contracting Boards	$2,260	$4,281
t-Test statistics	1.42	0.64

t-Test statistics, critical values for 27 degrees of freedom at:

1 percent significance = 2.473

5 percent significance = 1.703

One possible reason for this, which has already been suggested, is that there is much variation in the levels of contracting out within the group of contracting boards. To refine the analysis, the privatisation indices calculated in chapter six (table 6.5) were correlated with measures of financial constraint, housekeeping and dietary service cost effectiveness. As any effect of low operating grants or high housekeeping and dietary costs on the propensity to privatise would most likely be delayed, the correlations were time lagged. The financial constraint variable had to be based on the census years 1981 and 1986 because of the requirements for including cross boundary population flows in the standardisation. Regression analyses were then done with privatisation indices, calculated in exactly the same way as in chapter six, for 1983 and 1988 respectively. The resulting correlation coefficients are given in table 8.4.

TABLE 8.4: Correlation Coefficients for Privatisation, Financial Constraint and Cost Effectiveness of Hospital Boards Housekeeping and Dietary Services

	Financial Constraint	Cost Effectiveness	
	Operating Grant per Capita	Housekeeping Costs per Bed	Dietary Costs per Bed
		1981	
Index of Privatisation for 1983	-0.24	0.27	-0.06
		1986	
Index of Privatisation for 1988	-0.36	0.20	-0.04
Significance of r for 29 cases		= 0.45 (one percent) = 0.35 (five percent)	

A larger operating grant per capita would be expected to reduce the likelihood of privatisation and this contention is borne out by the negative correlations for both years. On the other hand high housekeeping/dietary costs per bed should precipate more privatisation in order to realise a more economical service. This again is confirmed by the positive correlation for housekeeping while for dietary there is virtually no relationship at all. Only for grant per capita and privatisation in 1986 is there a statistically significant correlation and then only at five percent. The absence of any relationship in the case of dietary may

possibly be explained on the grounds that, compared with housekeeping, there is far less contracting out of the service, there are different management structures, and greater levels of professionalism within the service as chapters five and six showed.

Rather than simply analysing these variables relative to each other at two points in time, it is also worthwhile to see how their change over time may have affected the levels of privatisation (table 8.5). Percentage changes between 1981 and 1986 for financial constraint and cost effectiveness were correlated with the indices of privatisation for 1988 and the results are given in table 8.6. From table 8.5 it is seen that the non-contracting boards showed slightly greater mean increases in ancillary costs per bed than the contracting ones. This however is to be expected and for the same reason as given above; the contracting group of boards would have been implementing cost savings for which there was much less scope for than in the non-contracting group. Also noteworthy is that the difference in changes to financial constraints between the two groups is negligible with *t*-Tests on the group means showing no statistical significance. The within group variations are therefore of more interest.

A board which has undergone a comparatively low increase in operating grant between 1981 and 1986 would be coming under greater financial constraint. It might therefore be expected to implement more privatisation than a board whose financial position had become less restrained with the operation of the population based funding formula. As predicted a negative correlation was found although it was too low to be significant while for changes over time in cost effectiveness no relationship was found with levels of privatisation.

The lack of statistical significance in any of the correlations clearly indicates that other factors beyond these considered here must be mediating the spatiality of the contracting out process. Taking into account the poor quality of the original data base, the results of the analysis are somewhat inconclusive. The original hypothesis that there is more contracting out where financial constraints are high and where cost effectiveness is low, is not entirely contradicted but neither is it unequivocally confirmed. In the following section consideration is given to possible regional variations in the political pressures that might dominate over any case for, or against, contracting out based on overtly economic criteria.

TABLE 8.5: Percentage Changes to Financial Constraints and Cost Effectiveness of Ancillary Services from 1981-86 and Levels of Privatisation for 1988

Hospital Boards	Financial Constraint ($/capita)	Cost Effectiveness ($/bed) Housekeeping	Dietary	Index of Privatisation
Commenced or Retained Contract Provision for Ancillary Services:				
Auckland	67.7	93.6	87.7	0*
Canterbury	58.4	83.0	91.8	15.4
Otago	55.3	63.3	83.8	14.9
Waikato	56.6	40.4	54.7	13.6
Wellington	62.4	-1.0	49.4	18.4
Hawkes Bay	76.6	63.6	78.6	27.2
Northland	55.9	20.5	68.3	66.7
S. Canterbury	75.0	72.9	105.3	29.6
Southland	63.0	57.1	139.8	93.7
Taranaki	58.2	14.0	73.6	28.6
Tauranga	72.2	79.4	103.0	62.2
West Coast	47.5	47.3	68.8	19.1
Ashburton	50.2	31.6	77.0	100.0
Bay of Plenty	62.1	38.8	37.5	97.5
Marlborough	53.8	28.4	72.5	60.6
S. Otago	56.1	72.9	90.6	65.2
Taumarunui	62.2	133.6	126.2	66.7
Thames	80.8	70.0	82.9	64.6
Vincent	36.5	50.1	52.8	100.0
Waitaki	66.3	32.8	102.9	50.2
MEAN	60.8	54.6	82.4	49.7
Terminated or Refrained from Contract Provision for Ancillary Services:				
Cook	62.5	68.8	69.7	0
Nelson	52.4	85.4	55.1	0
Palmerston North	69.4	70.7	133.5	0
Wanganui	72.4	58.0	59.2	0
Central Hawkes Bay	63.8	106.1	101.3	0
Dannevirke	53.2	35.0	93.5	0
Maniototo	60.0	-12.5	189.0	0
Waiapu	55.1	47.8	58.1	0
Wairarapa	73.5	68.6	71.5	0
MEAN	62.4	58.6	92.3	0
t-Test statistics	0.06	0.31	0.77	

t-Test statistics, critical values for 27 degrees of freedom at:

1 percent significance = 2.473

5 percent significance = 1.703

* Auckland ceased contracting out in 1988.

Data Calculated from Department of Health records, and *Hospital Management Data*

TABLE 8.6: Correlation Coefficients between Percentage Changes in Financial Constraint and Cost Effectiveness 1981-86 and Indices of Privatisation in 1988

	Percentage Changes from 1981 to 1986 in -		
	Operating Grant per Capita	Housekeeping Cost per Bed	Dietary Cost per Bed
Index of Privatisation for 1988	-0.21	-0.08	-0.06

8.6 Political Power and the Contracting Out of Ancillary Services:

Insofar as changed economic conditions provide a reasonable contextual explanation of the temporal dimension to contracting out at the aggregate level, the spatial dimension of the process is still left unexplained. In an attempt to gain a further understanding of the latter process the existence of political pressures for privatisation at both the national and regional level needs to be considered. As both Governments and hospital board members are elected, and not appointed, to political power, any pressure for privatisation from these quarters might be expected to reflect 'public choice' and hence the 'public interest'.

It has already been seen that in the very early phase of contracting out, little could be attributed to electoral political considerations. To the extent that directives from central Government had been issued to the boards, they had often been rejected and, moreover, no spatial variations in hospital boards' political composition could be discerned. A similar situation seems to have obtained in the 1970s and for much of the 1980s.

At the national level there has continued to be a strong political impetus towards private hospital care in general as evident from parliamentary speeches recorded in *Hansard*. Yet apart from the 1984 quote from the Minister of Health, cited earlier, no record has been found expressing commitment to the contracting out of ancillary services, both from Parliament or from its bureaucratic arm in the form of the Department of Health. For central government, at least, the ancillary sector of the public hospital system was still 'A Forgotten Sector' through to the 1980s. At the local level however, the situation in respect of the membership of hospital and area health boards, is worthy of further consideration.

A detailed review of the extent of democratic community representation by hospital and area health board members by Baker (1988) provides an informative account of political factors underpinning these institutions. Based on the contention that, "*competitive elections represent a major form*

of accountability within regional and district government" (Baker 1988, 6), the account demonstrates the limitations of hospital boards have had in representing this ideal. An important factor in increasing the potential for greater accountability of elected representatives, according to Baker (1988, 6) is party political membership. He maintains however that:

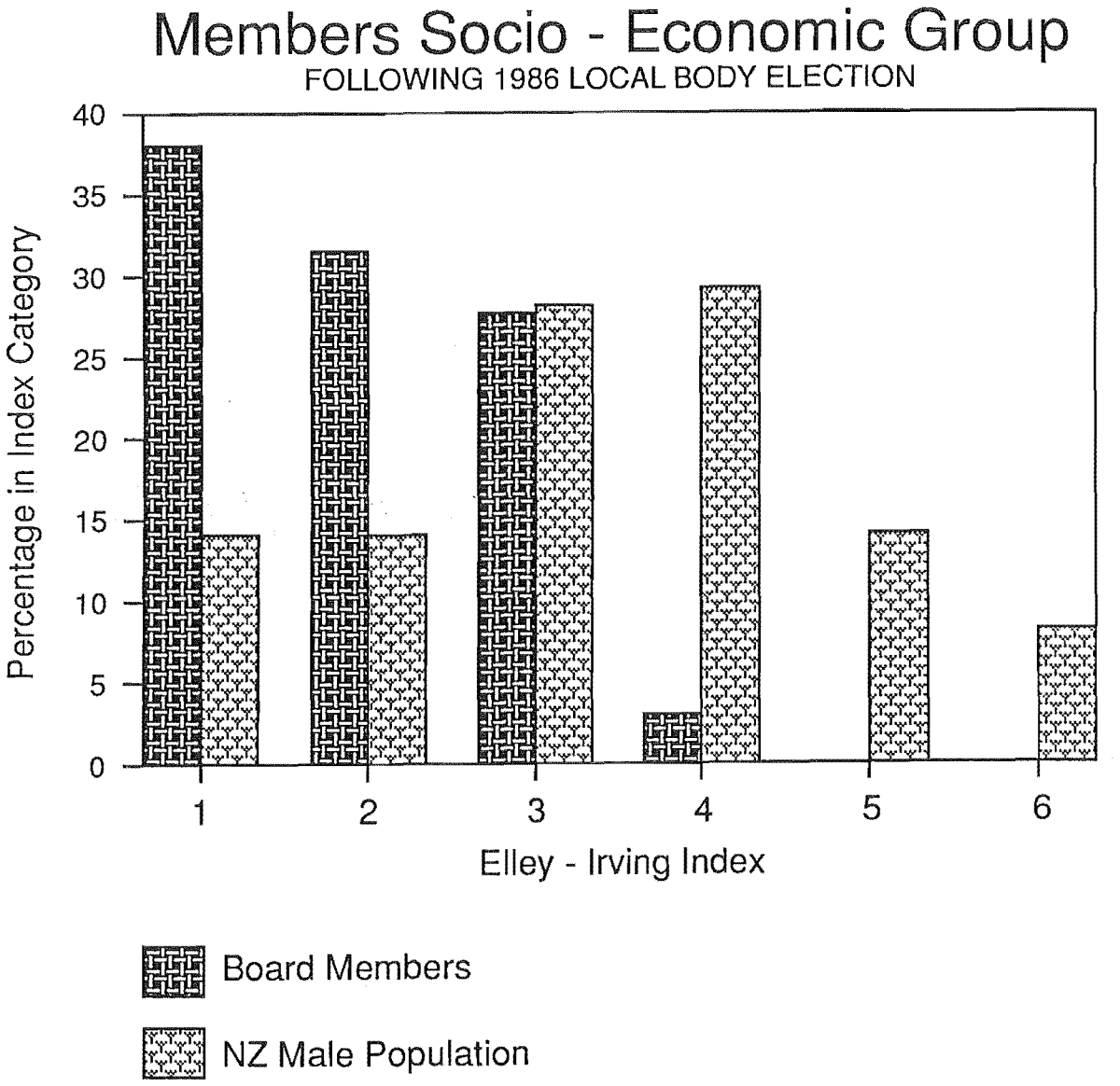
> only 13% of candidates in the 1983 hospital board elections stood on a party platform. This included 25 citizens and 38 Labour candidates. This is consistent with a dominant trend towards independent candidates in local body elections (the only exception being the city councils in the larger centres).

Local body politics in New Zealand, including the hospital boards, has traditionally been 'depoliticised' and this, as is argued below, may have tended to give local authorities a generally politically conservative bias.

The evidence for the existence of a politically conservative bias can only be indirect in the absence of political party affiliation but it is nonetheless suggestive from examining the socio-economic status and occupational categories of elected members. With reference again to Baker (1988), an analysis of the 1986 local body elections shows, in the case of hospital boards, an overwhelming proportion of members in socio-economic classes 1 - 3 as based on the UK Registrar General's Classification (figure 8.3). The figure was 96 percent for the boards as against 49 percent for the general population (Baker 1988, 4). Citing the work of Halligan and Harris (1978) and SCROW (1977), Baker (1988, 5) maintains that similar patterns were found in council members following the 1974 local body election and in analyses of school committees in the mid 1970s. In respect of hospital boards he argues that, "*the trend towards over-representation by upper socio-economic classes seems even more pronounced*" (Baker 1988, 5).

The occupational composition of hospital board members has also been skewed towards particular categories which is perhaps not surprising in view of the above. In 1986, 75 percent of board members could be classified as one of the following; health worker, farmer, home worker or retired, while a further 10 percent had business and legal occupations. Of the health workers, the first category comprised primarily, medics, paramedics, nurses and social workers. Very few people occupying wage-labouring positions, either within or outside of hospital services, have gained election to hospital boards. Halligan and Harris (1978) argue that the reason for this lies largely with the nature of the work required by board/council members:

Figure 8.3 Elected Members by Socio - Economic Group, 1986



Source: Baker 1988

> Although the job of being a councillor is regarded as a part-time role, much of the work occurs during the day, so it is necessary to have an occupation that is sufficiently flexible to allow for such demands. The occupations that meet this criteria tend to be of a particular type and to exclude those on the lower part of the SES scale (Halligan and Harris 1978, 241 cited in Baker 1988, 5).

Even though it by no means always follows that upper and lower socio-economic groups and occupational classifications cleave along party political lines into, respectively, conservative-radical axes, the composition of hospitals boards is indicative of there being an in-built politically conservative tendency. Where people have been elected on a Labour platform they have nearly always been in a minority in the board and have therefore had little scope to change established policies.

The relevance of this to the contracting out of ancillary services is that the class composition of board members has been quite different from that of hospital ancillary workers. The former belong predominantly to the so called 'professional, technical and managerial strata' or, in Marxian terms, 'new petite bourgeoise' (Wright 1976) whereas the latter are of the traditional working (proletarian) class. Contracting out and associated cost reductions to ancillary services have perhaps for this reason met with very little opposition from board members. The workers in these services, because of their anonymity within the administrative structure, can be convenientially forgotten about. The usual justification for cutting ancillary service costs, as put forward by hospital board management to board members is that, there will be relatively more funds available for direct patient care services - services from which many board members have been drawn.

Whatever the merits of the above argument, the difficulty of applying it to the spatio-temporal dimension of the contracting out process is that, as far as can be ascertained, the political structure of hospital boards has been fairly uniform across both space and time. The 1986 local body elections did see the election of two hospital ancillary workers to the Auckland Hospital Board, which certainly had a part to play in the termination of the contracts in that board. This case will be discussed further in a subsequent chapter but for the present, suffice to note, that this is the only example known of active worker participation in hospital boards and subsequent policy change in the form of ancillary service provision.

Rather than electoral political factors explaining the spatiality of contracting out, there is more plausibility in citing these factors as explaining the sectoral variation in contracting out as discussed in an

earlier chapter. Instead of appealing to public choice explanations, the effect of political factors on contracting out ancillary services can be better explained within the Weberian perspective based on the different levels of political power within the boards' administrative structures both at the level of the bureaucracy (managers) and the democracy (members). Also within a Marxian framework there is a clear class cleavage between the proletarian nature of the ancillary service workforce and the petit bourgeois, if not entirely bourgeois, membership composition of the boards.

The pressure on hospital boards from financial constraints and, to the extent that they existed, political forces still do not provide a satisfactory explanation of the uneven spatial development of contracting out in view of the very different policy options adopted by the boards. It has already been noted that where the contract option was either adopted, or retained, the claim for the greater cost savings of this form of service provision has rested on the basis of a lack of in-house management expertise being available. The precise nature of this alleged expertise requires further consideration in its relation to the uneven development of contracting out.

8.7 Managerial Considerations:

Since housekeeping and, to a lesser extent, dietary services, are highly labour intensive, the management expertise required demands more an ability to control the labour force rather than any detailed knowledge of complex technological processes. Therefore the savings made in this sector of hospital activity are realised mainly through increasing work intensity in order to reduce the size of the labour force, rather than by introducing labour saving technology. Essentially the expertise required to reduce the costs involves minimising the labour in-put for any given level of service provision. Why then have the hospital boards themselves not made the required cost savings by introducing new schedules with an appropriately reduced labour force?

A more fundamental reason than cost savings behind hospital boards contracting out housekeeping and dietary services seems to have rested on what may loosely be termed, 'managerial considerations'. In chapter two it was seen that in the (Weberian) theory of 'bureaucratic rationalisation', the ultimate aim of contracting out was to eliminate troublesome aspects of managerial responsibility. The foundation for this argument comes primarily from personal interviews with hospital boards' management staff. Perhaps not suprisingly, documented evidence on this is sparse since it does not reflect positively on boards' management skills but some indirect cross references have been found to support the contention.

In response to a suggestion that the Wairarapa Board should revert to contract provision again, a member of the management team cited the case of the Bay of Plenty Board where:

> A financial study was carried out sometime ago and that it would have been financially beneficial for them to carry out their own cleaning but they did not want to carry the burden of the hassles that would be involved (internal memorandum, Wairarapa Board, 29th October 1982, my emphasis).

More recently a Waikato Board staff member commented, in response to an earlier suggestion to extend the existing cleaning contract without retendering, that:

> At that time I was opposed to an extension as I considered Hospital cleaning could be done with our own forces cheaper. A review of the tender, and the conditions of employment that Crothalls give, soon proved my theory wrong. I could neither compete financially nor treat my staff in the same manner (internal memorandum, Waikato Board, 13th November 1987, my emphasis).

The implication is that through contracting out, hospital board management has been prepared to let others do what they have not been prepared to do themselves. In defense of this policy management has argued that contractors can more easily instill workforce discipline by dismissal, or threat thereof, since unlike the hospital boards, there has been no appeals procedure available. Anyone dismissed from a hospital board has had the right of appeal to the elected board members, although this procedure ceased with advent of the general manager concept of administration in 1988. The boards therefore have had to adhere to a 'good employer' policy in a way which contractors have not, but whether a 'hire and fire' mentality is any more conducive to higher labour productivity than one of secure employment may be highly questionable. Whatever the case may be the rationale underlying the contracting out of domestic services in the Otago Board in 1982 is instructive to consider.

A management report to the (elected) membership maintained that they could not achieve further cost savings in domestic services because of difficulties with industrial relations. According to the report the industrial problems related to restraints imposed by the trade union on labour force reduction, redeployment and productivity and the claim was made that:

> The intransigent attitude revealed by the local Branch of the Domestic [Hotel and Hospital] Workers Union in their approach toward the Board's difficulties with cost constraints highlights the problems faced by management in this area (Managememt Report to Otago Board 11th March 1982).

The conclusion that the management team came to was that:

> It is clear that further significant savings can be made in this

> area (emphasis in original)...[and]...There can be no justification in a soft management approach (my emphasis) to our serious and pressing cost containment problems (Management Report to Otago Board 11th March 1982).

So rather than dealing with the situation themselves, arguably the 'soft management approach' was taken by the decision to contract out the service and thereby give the 'hard management approach' to someone else; a private contractor. No reason was presented in either this report or in the case of Waikato, as to why the contractors, but not the management staff, could tackle the 'intransigent attitude' of the union.

It is difficult therefore to avoid the conclusion that contracting out took place, not so much for financial reasons, but to avoid having to undertake a difficult administrative problem in the field of industrial relations. Instead of being a matter of economic efficiency, as contracting out might at first appear, the process is rather a symptom of managerial inefficiency even though set in a framework of 'bureaucratic rationality'. Previous work though has pointed to cases in which contract services have been brought back under board provision and this counterposing process has also had an underlying rationality of its own. While the stated reason in written documents for this has virtually always been financial, through the elimination of payouts on contractors' profits, management staff have often reported verbally on the greater control thought possible over the workforce by not having to work through a third party in the form of a contractor.

The opposing arguments advanced by board managements for, or against, contracting out could more usefully be seen a being indicative of the contradictory position in which they operate rather than in relative degrees of (in)efficiency. Hospital board management staff are expected to act as if they are employers (of ancillary workers) while they are themselves still employees of the board. Being trade union members (Clerical Workers Union) they have their employment conditions negotiated in the same way as the ancillary workers with the exception of the chief and deputy chief executive, whose renumeration is set by the Higher Salaries Commission.

With managers being in an employee situation it is perhaps not surprising that they have opted for whichever form of service provision entails the least administrative (ie work) burden. At least by contracting out a service they relieve themselves of the double, and inherently contradictory, burden of being both employer and employee[3]. Their frequent, although by no means universal, advocation of the policy should rather be seen as a reflection of the structural contradictions under

which they operate rather than of any specific management inability as such.

Conclusion

To conclude the debate it can be said that the underlying basis for contracting out does not appear to be so very different from the 1950s and 1960s. The stated reasons have been very different in each case, as have been the socio-economic conditions, - respectively, labour shortages and economic expansion as against cost savings and economic recession. But the concept of bureaucratic rationality appears to have been a common basis to contracting out from the earliest times. More specifically, in the early period the process divested management of labour recruitment problems, whereas in more recent times it has been invoked to avoid confronting problems of labour force unrest, whether threatened or existing. The exercising of management prerogative is then likely to be mediated spatially by regional variations in the industrial strength of the workforce.

Contracting out, as this and the previous chapters have shown, is not a universally adopted response to fiscal constraints and management decisions. Consideration must also be given to the nature of the labour force concerned. Hitherto it has been treated as merely a passive bystander on the scene. Both public choice and managerialist theories are predicated on factors that predispose public bureaucracies to adopt private contracting. Arguments based on cost savings (public choice) and bureaucratic rationalisation (managerialist) are too deterministic as they assume a unilinearity in the direction of the contracting out process and the theories can both be applied aspatially. Clearly such a unilinearity does not exist in social reality. Therefore the social forces, or in terms of Marxian political economy, the class forces that may influence the contracting out process must also be considered to complete the analysis of geographically uneven privatisation. It is to this issue that the next chapter is addressed.

Footnotes:

1 The quantity, average occupied beds, is defined as:

$$[\sum(\text{bed days})]/365$$

2 As was pointed out in chapter seven, data given in the form of rates is not strictly applicable to *t*-Tests because the group mean values are not the same as the mean of the individual rates. The *t*-Tests were nonetheless conducted because of the lack of alternative testing procedures.

3 The contradictory position of hospital managers is exemplified through their trade union membership. On the one hand they are employees and

belong to the Clerical Workers' Union while on the other hand they are employers of members of the Hotel and Hospital Workers' Union - the ancillary staff. At national Award negotiations an individual hospital manager may find him/herself on the union side of the bargaining table for the Clerical Workers' Award and on the employers' side for the Hotel and Hospital Workers' Union.

CHAPTER 9

Contracting Out and Class Conflict

In this chapter the issue of labour relations or, when stated more controversially class conflict, is discussed in respect of its likely mediation in the geographically uneven development of contracting out public hospital ancillary services. The opposition to private sector contracting by the ancillary sector workforce, while having roots back in the early seventies, did not gain significant momentum until the early eighties. It has virtually coincided with the advent of national economic recession and the start of major restrictions on central government funding to hospital boards. As the previous chapters showed the ancillary service sector of public hospitals has undergone the most stringent financial cuts in the 1980s and consequently in such a labour intensive industry, the workforce has been particularly affected. Therefore the advent of increased labour militancy during this same period has not been coincidential.

The chapter is presented in three parts. The first part discusses the rationale behind worker opposition to contracting out as expressed by their trade union representatives. A comparative analysis is made of the employment conditions of ancillary workers under hospital board and private contact employment. The second part presents an account of the policies adopted by these workers, through their trade union organisation, to combat the existence, and potential expansion, of private sector contracting in public hospitals. In this section attempts are made to explain the uneven spatiality of contracting out with reference to regional variations in the strength of labour force opposition. To provide further illustration of the role of class struggle in mediating the geography of privatisation, some particular case studies are presented in the final part of the chapter.

9.1 The Rationale for Labour Force Opposition to Private Contracting of Hospital Services:

Earlier chapters have shown that contracting out ancillary services has predominated in the domestic cleaning sector. On this basis the policy prescription of the Hotel and Hospital Workers' Union[1], which represents nearly all ancillary workers, has been simply to, 'clean out contractors' (figure 9.1) from the public hospital system and indeed all other areas of the state sector. The rationale for this policy of opposition to private contractors is also given in figure 9.1 directly beneath the headline. To summarise the three objections cited, there is an ideological aversion to private profit from public service, an alleged lack of public

FIGURE 9.1: Trade Union Policy on Contracting Out Public Servivces

CLEAN OUT CONTRACTORS

The New Zealand Trade Union Movement is totally opposed to private contractors operating within the Health system, the Education system, and other areas of the Public Service.

We are opposed to private contractors for the following reasons:

- we believe public money should not be used for private profit-making. Contractors are not involved in the Public Service because they are community-minded. They are there to make as much profit as they can.
- we believe that all areas of the Public Service should be directly accountable to the public. It is more difficult to make a private contractor accountable for its actions than a publicly elected Hospital or Education Board.
- despite their promises, private contractors make their profits through cutting working hours, increasing workloads and lowering standards of the service being offered.

Source: New Zealand Hotel and Hospital Workers' Union.

accountability on the part of private contractors and a deterioration of employment conditions and standards of service provision consequent upon contracting out to the private sector.

It may be argued that the ideological aversion to private enterprise in public services stems largely from the empirical observation of the effects of the privatisation process as detailed in the second and third objections just cited. These objections are worthy of further investigation in view of the enoromous significance that the trade union movement has attached to them. The issue of accountability is considered first.

9.1.1 Public Accountability and Private Contacting of Hospital Services:

Notwithstanding the limitations of the public accountability provided by elected hospital boards, as detailed in the previous chapter, the main stand of the trade union has been that these boards are at least nominally accountable to the public through periodic elections. Hospital board members are empowered to provide substantial control over management staff and can be voted out of office if in default of their responsibilities. On the other hand, neither company shareholders nor directors are subjected to such constraints and public recall.

It was seen in chapter six that all spatial scales of capital (business) have been involved in providing hospital ancillary services, from the distinctly local to the multinational. At both ends of these scales there have been problems of accountability that have been of direct concern to the work forces involved. In the case of very small, and some not so small, private operators contracts have often been obtained by undercutting larger operators. The former do not have such overhead costs and therefore, superficially at least, appear economically attractive for financially hard pressed hospitals to engage. Frequently undercapitalised in relation to the size of their operation, these small companies are very prone to bankruptcy. McCready (1981, 1), writing in the trade union journal *HOSP*, argued that:

> In this situation [of bankruptcy], the Union which has almost certainly been fully involved for some time trying to see that staff receive the correct Award wages has to get in and pick up the pieces for members who have been left with wages and holiday pay owing from the bankrupt contractor.

Sometimes called, 'cowboy' contractors to the people who suffer their consequences, these organisations can almost literally be, 'here today and gone tomorrow' and all public accountability along with them.

At the other end of the spatial scale the problems of public accountability with multinational companies are legion. Since they are

well documented in the geographical literature on industrial restructuring (eg Susman 1981, Ross 1983, Trachte and Ross 1985) they need not be elaborated upon here. In the particular case of hospital services, where multinationals are the contractors, bankruptcy and overnight disappearance are not so much the problem. Rather their enormous resources and diversified operations, can present serious difficulties for public authorities, like hospital boards, in ensuring that they adhere to the terms of contracts. For the workforces concerned these companies can withstand prolonged industrial action in the event of failure to reach or maintain negotiated agreements with work forces.

The issue of accountability has not only been a concern for the trade unions trying to advance, or at least maintain, the conditions of employment of their members. The hospital boards themselves have often experienced great difficulty with ensuring adequate standards of service provision especially when in a very competitive environment. A poignant example of this, which verges on the humourous were it not so potentially serious, was reported by the Auckland Board as follows:

> Many requests have been made for standards to improve.... A practice has been adopted whereby old cordial bottles are used to store detergents which resulted a few weeks back in a serious incident. A cordial bottle was left on top of a refrigerator containing detergent, a nurse drank some and had to receive medical treatment. Your staff were spoken to but still the practice persists (Written communication to Crothalls Ltd., 21st September 1987).

Regarding financial reliability, a hospital board, just as much as a trade union, does not want a contractor to go bankrupt in the middle of a contract, in view of the service disruption it causes. This lesson was learnt by the Otago Board as far back as 1974 when the contractor stated baldly, "*We will have to liquidate as at 16th June 1974. We can't financially carry on with the Contract*" (Minutes of meeting between Otago Board and Vacuum Cleaning Company 12th June 1974). This resulted in the Board having to assume service provision itself. The inherent difficulty of public accountability of contractors is further apparent from the frequent need for hospital boards to ensure strict quality control of contract-provided services and to investigate thoroughly the business reputation and financial status of all contractors before engaging them.

9.1.2 Employment Conditions of Public Hospital Ancillary Workers:

If the changes in the costs and standards of service provision are the prime concern of the hospital boards, then changes in the staff numbers and their employment conditions are decidedly the concern of the workforce and its representative trade union. Only insofar as the latter affects the

former are they of interest to employers, whether in the public hospital (board) or private (contractor) sector. One of the main targets therefore of economies in housekeeping and dietary expenditure has been the trimming of the labour force and, as seen in the previous chapter, the involvement of the private sector has often, although by no means always, been thought to be instrumental in achieving this end.

Superficially there would appear to be little difference in employment conditions between contract and board employment for ancillary workers. Under existing industrial legislation in New Zealand all hospital workers are covered by an annually negotiated, nationally based Award[2] document. The conditions of the Award apply whether workers are, a) employed in the state sector or in the private sector - that is by the hospital boards or by contractors or b) employed as cleaners, orderlies or dietary service workers. These conditions govern such factors as minimum hourly wage rates, overtime and unsocial hours payments, holiday, long service and sick leave entitlement and rights to a minimium notice of dismissal.

Structurally then the conditions between employment by (private) contractors and by (public) hospital boards are identical[3]. The contentious issues relate primarily to the numbers of workers employed, the security of employment from arbitrary dismissal, the general flexibility of their hours of work and the work intensity required within them. In respect of wages, the rates are covered by the national Award but the 'take home' pay can drop substantially with the change to employment by private contractors. Weekend and night work, which attracts enhanced pay rates, may be greatly reduced and formerly full time, eight hour jobs may be reduced to part time ones, all of which entails reduced pay packets even though still adhering to the statutory pay rates.

Many other difficulties have also been encountered with contract employment notwithstanding the continuity of pay rates and formal conditions. A report on contracting out for the Hotel and Hospital Workers' Union (Mullins 1987) summarised many of the problems confronted by workers employed by Crothalls Ltd. at Auckland Public Hospital and is worth quoting at length:

> - Crothalls management not sticking to agreements with the union about disputes. This resulted in endless meetings and negotiations to resolve problems.
> - impossible workloads due to staffing levels sinking and people not brought in to replace workers on sick leave or annual leave etc.
> - no duty lists, workers moved randomly around the hospital instead of having set areas.
> - lack of consultation with workers or union about changing shifts or workloads.

- workers expected to produce medical certificates whenever they are sick (the award provides that a medical cerificate is only necessary after 3 consecutive days sick leave)[4].
- people received short pay due to problems with Hamilton making up pay.
- workers returning from maternity leave were put in less favourable positions.
- supervisors were given cleaning work when their jobs are supervising only.
- there is not enough equipment and it is run down (Mullins 1987, 10).

The main response of the contractors to these arguments has been articulated by Crothalls in a report of their activities presented to the Minister of Health in 1986 in the wake of a large industrial dispute in the Northland Board in 1985. Their main stance has been that trade unions oppose contractors being involved in the health system because:

> we [Crothalls] are fair but firm employers who ensure that our staff do 'a fair day's work'....[and]..... we have been exceedingly patient despite what can only be described as extreme provocation and have in the main avoided major industrial conflicts. (Report by Crothalls to Minister of Health, 1986).

Regardless of the validity of these claims and counterclaims industrial relations have often been exceedingly strained. One point however upon which contractors, hospital boards and the trade union are in agreement; substantial staff reductions have occurred through contracting out. The next section looks at this issue more closely.

9.1.3 Ancillary Sector Workforce Reductions:

Where services are contracted out under conditions of competitive tender, most contractors tender on the basis of performing the service at a lower price, and hence with fewer workers, than under the previous arrangement, whether this was by in-house provision or by an existing contract. Competition in the market place virtually obliges the contractors to take this price cutting, and hence job cutting, course of action. Understandably enough the trade union's stance has been one of opposition to all redundancy.

In view of this likely opposition, the boards and contractors have often disagreed over who should bear responsibility for job losses through paying for any redundancy deal negotiated with the trade union. Contractors often maintained that this issue was the responsibility of the hospital board since it was they who made the decision to change the terms of a contract either by negotiation or competitive tender. For their part hospital boards usually argued that, as the contractor was the employer, then the responsibility resided with the company for the consequencies of redundancy.

In most cases the position of hospital boards has prevailed but as a compromise solution a 'waste out formula' has often been implemented. The agreement has been for the board to pay those workers, deemed to be surplus to requirements by the incoming contractors, until they leave the job whereupon they would not be replaced. Such an agreement has sometimes proved costly to the boards concerned especially where labour turnover has been low as in many parts of New Zealand outside the major centres of population during the 1980s. Consequently some hospital boards have found themselves paying out for surplus staff for much longer than ever anticipated. In other cases where no such agreement has been entered into, the trade union has been able to achieve, often only after protracted struggle, a similar end in which job loss was to take place through 'natural wastage' or attrition rather than redundancy. Under these circumstances the contractors themselves have then had to bear the burden of 'excess' staff. According to Crothalls:

> ...despite very significant staff reductions over the last ten years we have not declared any individual redundant but have relied on natural attrition to bring staff numbers down to the required levels. This has cost the company hundreds of thousands of dollars and it is our belief that this union unlike many others in New Zealand has yet to come to terms with current economic realities (Report by Crothalls to Minister of Health, 11th June 1986, my emphasis).

Data on the number of staff employed by the hospital boards in the housekeeping and dietary services is recorded from 1975 onwards in *Hospital Management Data* just as with the financial data. Unfortunately the numbers of contract staff employed in these services has only been recorded since 1984 when the Department of Health Statistics required the hospital boards to acquire this information from contractors. Even though prior to 1984 no requirement for such statistics existed, some boards had been asking the contractors to supply them but, except for a very few cases, it has not been possible to detail the staff numbers employed as far back as 1975. Neither has the required data been available from the contractors concerned since records have either not been kept or else been lost, with the latter occurring especially where there has been a change of contractors.

In tables 9.1 and 9.2 data is given, respectively, on changes to housekeeping (domestic and orderly) and dietary staff numbers for the period 1980 to 1988 for those hospital boards from whom a comprehensive set of data could be obtained. Where applicable, the figures are given as an aggregation of board and contract staff. Although data prior to 1980 is very sparse, what is available has been shown for 1975 to counter the

TABLE 9.1: Staff Reductions in HOUSEKEEPING Services 1980-1988

Commenced or Retained Contract Provision for Ancillary Services:

Hospital Boards	1975	1980	1984	1988	Percentage Changes 1980-84	1984-88	80-88
Canterbury	*	619.7	489.2	470.9	-21.1	- 3.7	-24.0
Otago	417.2	436.7	312.0	253.7	-28.6	-18.7	-38.2
Hawkes Bay	253.4	231.0	162.4	162.3	-29.7	0	-29.7
S. Canterbury	*	84.9	78.5	78.2	- 7.5	- 0.4	- 7.9
Taranaki	*	204.8	177.7	160.8	-13.2	- 9.5	-21.5
Tauranga	*	97.0	82.7	92.1	-14.7	+11.4	- 5.1
West Coast	*	116.2	110.1	102.2	- 5.2	- 7.2	-10.3
Ashburton	*	49.9	35.8	30.3	-28.3	-15.4	-39.3
Bay of Plenty	*	71.8	53.5	53.1	-25.5	- 0.7	-26.0
South Otago	37.0	42.0	28.5	19.5	-32.1	-31.6	-53.6
Thames	71.4	67.9	60.4	46.2	-11.0	-23.5	-32.0
Vincent	*	14.2	10.2	8.5	-28.2	-16.7	-40.0
Waitaki	*	39.4	28.8	22.5	-26.9	-21.9	-42.9
TOTAL		2,075.5	1,629.8	1,500.3			
Group mean values					-21.5	- 7.9	-27.7

Terminated or Refrained from Contract Provision for Ancillary Services:

Cook	115.1	92.6	79.1	80.2	-14.6	+ 1.4	-15.5
Nelson	*	147.4	131.1	133.9	-11.1	+ 2.1	- 9.2
Palmerston N	*	281.2	259.9	256.8	- 7.6	- 1.2	- 8.7
Dannevirke	*	31.3	22.7	28.9	-27.5	+27.3	- 7.7
C. Hawkes Bay	49.3	50.4	41.9	38.6	-16.9	- 7.9	-23.4
Maniototo	*	5.2	5.4	5.2	+ 3.8	- 3.7	0
Waiapu	10.8	9.5	8.0	7.0	-15.8	-12.5	-26.3
Wairarapa	85.9	75.0	69.3	72.4	- 7.6	+ 4.5	- 3.5
TOTAL		692.6	617.4	623.0			
Group mean values					-10.9	+ 0.9	-10.0

* Data not available

t-Test results on group mean values for percentages changes

	t_{calc} calculated:
1980-1984	2.72
1984-1988	1.63
1980-1988	3.05

$t_{critical}$ for 19 degrees of freedom:

1% significance	2.539
5% significance	1.729
10% significance	1.328

Data Source: *Hospital Management Data*, 1975, 1980, 1984 and 1988.

TABLE 9.2: Staff Reductions in DIETARY Services 1980-1988

Commenced or Retained Contract Provision for Ancillary Services:

Hospital Boards	1975	1980	1984	1988	Percentage Changes 1980-84	1984-88	80-88
Auckland	404.0	596.2	543.9	603.9	- 8.8	+11.0	+ 1.3
Otago	*	221.9	211.8	176.3	- 4.6	-16.8	-20.5
Waikato	*	482.1	456.3	422.2	- 5.4	- 7.5	-12.4
Wellington	*	335.2	368.6	352.3	+10.0	- 4.4	+ 5.1
Hawkes Bay	62.8	78.9	74.6	75.5	- 5.4	+ 1.2	- 4.3
S Canterbury	36.8	39.1	38.5	38.2	- 1.5	- 0.8	- 2.3
Southland	56.3	57.2	54.7	53.2	- 4.4	- 2.7	- 7.0
Taranaki	66.8	70.9	68.2	77.2	- 3.3	+13.2	+ 8.9
Tauranga	36.5	39.9	35.8	37.3	-10.3	+ 4.2	- 6.5
West Coast	*	60.2	48.4	50.1	-19.6	+ 3.5	-16.8
Marlborough	20.7	23.2	20.4	20.4	-12.1	0	-12.1
South Otago	18.7	20.4	18.5	16.7	- 9.3	- 9.7	-18.1
Taumarunui	17.3	17.1	17.8	17.9	+ 4.1	+ 0.6	+ 4.7
Vincent	*	6.5	7.0	6.4	+ 7.7	- 8.6	- 1.5
Waitaki	*	14.6	13.2	13.1	- 9.6	- 0.8	-10.3
TOTAL		2,063.4	1,977.7	1,960.7			
Group mean values					- 4.2	- 0.8	- 5.0
Terminated or Refrained from Contract Provision for Ancillary Services:							
Cook	*	61.5	65.9	59.1	+ 7.2	-10.3	- 5.1
Nelson	*	134.4	125.9	105.2	- 6.3	-16.4	-21.7
Wanganui	*	142.7	119.3	109.8	-16.4	- 8.0	-23.1
Dannevirke	*	9.1	8.3	12.3	- 8.8	+48.2	+35.2
C Hawkes Bay	10.8	12.4	11.3	11.4	- 8.9	+ 0.9	- 8.1
Maniototo	*	3.0	2.2	2.2	-26.7	0	-26.7
Waiapu	*	8.3	7.2	7.0	-13.3	- 2.8	-15.7
Wairarapa	19.0	19.8	22.4	22.0	+13.0	+ 1.8	+11.1
TOTAL		391.2	362.5	329.0			
Group mean values					- 7.3	- 9.2	-16.0

* Data not available

t-Test results on group mean values for percentages changes

	$t_{calculated}$:
1980-1984	1.34
1984-1988	1.88
1980-1988	3.18
	$t_{critical}$ for 21 degrees of freedom:
1% significance	2.518
5% significance	1.721
10% significance	1.323

Data Source: *Hospital Management Data*, 1975, 1980, 1984 and 1988.

possibility that the staff reductions in the eighties may have simply continued a pre-existing trend. In a few instances this seems to have been the case but in the main, numbers increased slightly to around 1980 and then reduced significantly thereafter.

For comparative purposes, and following the methodology of the previous chapters, the hospital boards in tables 9.1 and 9.2 are grouped according to the form of service provision adopted; contract or in-house. Taken over the complete period 1980-88, both services under both forms of provision have undergone substantial staff reductions and a *t*-Test on the group mean percentage changes revealed differences between the two groups to be statistically significant even at 1 percent. For the contracting boards, housekeeping showed greater reductions than dietary services whereas the situation was reversed for the non-contracting boards.

This may possibly be explained on the grounds that all boards except South Otago and Vincent, in the contracting group provided their dietary services in-house and contract provision was confined strictly to the housekeeping sector. As already seen in this thesis, dietary services have not been subjected to the process of contracting out to anything like the extent of housekeeping. A further noteworthy feature is that in both services the major staff reductions occurred mainly in the first half of the period under consideration (1980-84), although only in housekeeping was the contracting group reduction, in statistical terms, significantly greater than in the non-contracting group. This greater staff reduction in the first period would be expected in view of all the changes in contracting out policies that occurred in the early 1980s and the associated managerial scrutiny to which the ancillary services were exposed.

Within the terms of the theoretical frameworks of the thesis it might be expected that regional variations in the increase of government financial restrictions to hospital boards would have a spatially varying affect on staff reductions. Accordingly percentage changes in operating grants per capita for the period 1981-86 (as used in table 8.5 of chapter eight) were correlated with percentage changes in housekeeping and dietary staff between 1980 and 1988 (table 9.3). The use of a longer time period for staff changes than for financial changes is justified through the need to allow for a time lag between cause (financial constraint) and effect (staff cuts). As expected a positive correlation was found between changes to operating grant and staff changes both for housekeeping (r = 0.30) and dietary (r = 0.21) although neither is statistically significant. Staff numbers have therefore tended to show the lowest increases, or rather

TABLE 9.3: Percentage Changes to Hospital Board Operating Grants (per capita) 1981-86 and Ancillary Staff 1980-88

Hospital Boards	Percentage Changes to: Operating Grants	Housekeeping Staff	Dietary Staff
Commenced or Retained Contract Provision for Ancillary Services:			
Auckland	67.7	*	+ 1.3
Canterbury	58.4	-24.0	*
Otago	55.3	-38.2	-20.5
Waikato	56.6	*	-12.4
Wellington	62.4	*	+ 5.1
Hawkes Bay	76.6	-29.7	- 4.3
Northland	55.9	*	*
S. Canterbury	75.0	- 7.9	- 2.3
Southland	63.0	*	- 7.0
Taranaki	58.2	-21.5	+ 8.9
Tauranga	72.2	- 5.1	- 6.5
West Coast	47.5	-10.3	-16.8
Ashburton	50.2	-39.3	*
Bay of Plenty	62.1	-26.0	*
Marlborough	53.8	*	-12.1
South Otago	56.1	-53.6	-18.1
Taumarunui	62.2	*	+ 4.7
Thames	80.8	-32.0	*
Vincent	36.5	-40.0	- 1.5
Waitaki	66.3	-42.9	-10.3
Terminated or Refrained from Contract Provision for Ancillary Services:			
Cook	62.5	-15.5	- 5.1
Nelson	52.4	- 9.2	-21.7
Palmerston North	69.4	- 8.7	*
Wanganui	72.4	*	-23.1
Dannevirke	63.8	- 7.7	+35.2
C. Hawkes Bay	53.2	-23.4	- 8.1
Maniototo	60.0	0	-26.7
Waiapu	55.1	-26.3	-15.7
Wairarapa	73.5	- 3.5	+11.1

Data calculated from Department of Health records, *Hospital Management Data* and figures supplied by hospital and area health boards and contracting firms

* = data not available

greatest decreases, where the increase in operating grant has been lowest although the correlation is very weak.

Nevertheless, despite the weakness of this association, jobs have certainly been lost in the hospital ancillary sector particularly in the housekeeping services. Moreover the contracting out of these services would certainly have been a major factor in achieving this in view of the cost savings thought possible. But beyond the issue of job loss alone, the industrial relations scene has probably been exacerbated by the nature of hospital ancillary services themselves.

It was seen in chapter five that the services considered here, especially cleaning and orderly work, are highly labour intensive and, unlike many other industries outside of the health sector, it has not been possible to reduce the workforce significantly by introducing new technology. This is not to say that modern machinery and cleaning agents have not played a part in reducing staff but rather, in spite of these advances, productivity increases have had to come more through intensifying the physical nature of the work process - that is through work speed-ups. It is therefore hardly surprising that substantial workforce resistance has been encountered.

The last two decades have seen many labour intensive manufacturing industries, employing skilled and semi-skilled workers, relocate to the Third World on account of the readily available pools of cheaper labour. Clearly this cannot be done with the hospital services and hence the contradictions of workforce resistance to productivity pressures has had to be resolved *in situ* rather than by exercising the option of geographical mobility. An inherently labour intensive and spatially fixed industry has meant that productivity increases have placed great physical pressure on the workforce. In the next section some of the consequences of, and resistance to, this pressure applied by contractors are examined.

9.2 Trade Union Policy and Contracting Out Ancillary Services:

A consideration of the theoretical frameworks introduced in chapters two and three would suggest three possible means by which workers can combat privatisation. From a public choice perspective they might campaign to raise public awareness of what trade unions see as private contractors lack of public accountability and responsibility for deteriorating standards of public (hospital) service provision. This would probably be supplemented by campaigns for election to the hospital boards in which the political power achieved is used to inhibit or reverse any contracting out policy.

A Weberian (managerialist) approach to the issue might entail the workforce attempting to acquire relevant occupational skills or knowledge in order to 'professionalise' their status. On the basis of 'knowledge is power', they could expect to attain a greater degree of authority or at least bargaining power in the policy making decisions of the hospital boards in respect of contract service provision. The final way of combating the process comes within the Marxian perspective. This policy necessitates class action at the point of production by the workforce withdrawing its labour from service provision until certain conditions are met such as the termination of a private contract.

The first two policy options have already been covered in earlier chapters, albeit in a different context, and found problematic. For the public choice perspective, the heavy time commitment of hospital board members and the need for ancillary workers to earn a living makes it exceedingly difficult for the latter group to participate actively in the former. The principal, if not the only example, of electoral politics influencing hospital board contracting out policy is considered later in this chapter. With regard to professionalism, ancillary services are inherently unskilled, or at best semi-skilled, and there are few opportunities available for acquiring professional job related qualifications. It is perhaps not surprising then that the main oppositional thrust against contracting out has been focused on the point of production itself.

A campaign of industrial action against contract employment developed in the 1980s but this policy must also be seen as part of a broader campaign to involve the workforce in trade union affairs and the maintenance of the public hospital system. In the words of a prominent official of the Hotel and Hospital Workers' Union:

> The whole drive was to bring the union back to the members. If they felt an action by an employer was unjust, they had to decide: does it go to court again or should they take direct industrial action. We advocated a direct response to injustice rather than waiting for the legal system to take effect.
>
> We also improved communications with members. We started a union newspaper, published a training manual, hired an education officer, elected more delegates and got all of them more involved with the decision making process (*Metro*, 1989, 116).

The previous chapter showed that contracting out can be a way of divesting management of administrative responsibility. This policy though may only be viable to the extent that services are still provided once contracted out. Should major industrial conflict occur, so that services are disrupted, then the desired effects of privatisation may not

be achieved and there might have to be a reversion to state provision. At the very least the effects of privatisation in terms of job loss and wage cuts may be minimised by an industrially organised workforce and, moreover, just the potential of major conflict could inhibit the execution of privatisation policies because of the anticipated disruption to services. It might therefore be expected that the geographical development of privatisation would be mediated by the extent of work force opposition; in effect the level of class conflict. From within a Marxian framework, the balance of class forces could be of critical importance in the development of privatisation policies.

The critical issue then is to test empirically the theoretical proposition that spatial and temporal variations in the level of class conflict, or workforce militancy, mediate the uneven development of privatisation. This requires determining quantitatively whether in any given service or institution, the workforce in region A is more or less militant than in region B. In terms of this study, there is a need to find out which hospital board districts have had the most militant ancillary workers and relate this militancy to the spatial development of contracting out. By analogy with the index of privatisation developed in chaper five, a numerical index of class conflict needs to be established.

9.2.1 An Index of Class Conflict:

As first seen in chapter two, Peet (1983) constructed a single composite index of levels of class struggle by ranking all States in the USA in terms of differences in numbers of work stoppages, union membership, wage rates, and 'business climate'. The latter variable was taken as a measure of the (local) state's attitude towards capital and labour and comprised measures of tax levels, union and corporate legislation, the size of government and other indices showing how favourable the attitude of the local state was towards business (Peet 1983, 124). Within the context of this case study such a comprehensive index is not possible.

In New Zealand union membership and wage rates have remained, respectively, universal and uniform across all hospital boards throughout the duration of time for which data is available (ie around the mid 1970s). Apart from a period of voluntary unionism from February 1984 to May 1985, which did not significantly affect hospital domestic workers, there has been a universal union coverage for most industrial occupations in New Zealand. While not denying the existence of some spatial variations in wage rates outside the hospital sector (see Hoare 1986), the wage rates in the hospital ancillary sector, have been set nationally, not regionally or locally, hence their aspatiality. For the most part New Zealand wage rates

vary across industries not regions. In respect of business climate no such regionally based index exists in New Zealand as it does in the USA. This is primarily because of the more centralised government administration and a nationwide application of all industrial legislation in New Zealand with no regionally specific variations.

The only remaining variable to indicate class conflict in Peet's formulation is the levels of work stoppages but even with this several empirical difficulties were encountered in trying to quantify it. Not the least of these difficulties arose from a lack of official data. The main statistical source on this subject in New Zealand has been the Department of Statistics annual publication, *Work Stoppages and Industrial Unions*[4]. Unfortunately it does not contain a sufficient disaggregation of data to detail work stoppages in public hospitals and therefore the publication is of little assistance in this case study.

Another important factor to consider with collating data on work stoppages is the particular form in which to present the information. Work stoppages, whether complete, as with strikes, or partial, as in the banning of certain duties, can be classified according to the number of either stoppages themselves, working days lost or workers involved. So a year with a low number of stoppages might have a high number of working days lost and vice versa, with a very different perspective on the level of class conflict emerging according to which particular statistic is used. There are also a great many workplace activities that could plausibly be regarded as class conflict or militancy but are not in any way quantifiable such as, sabotage of machinery, unofficial 'go-slows', absenteeism and deliberate policies of non-cooperation with the employer. A further unquantifiable factor is the extent of threatened work stoppages which do not come to fruition because of either a retraction by one or both parties or a mutual compromise. Therefore in collating data on this issue there is the inherent danger of seriously underestimating the extent of labour force militancy.

With the absence, or at least the inapplicability, of official statistics, the data on work stoppages by public hospital ancillary workers has had to be gathered at first hand. Data was sought from each branch of the Hotel and Hospital Workers' Union on the work stoppages, whether complete or partial, that have occurred in public hospitals throughout the four decades in which contracting out has existed. The incompleteness of many trade union records made it necessary to rely on the memories of workers and union officials and the fragments of records on this issue belonging to hospital boards all of which has made verification exceedingly

difficult.

Another contributory factor to the difficulties of quantification has been the degree of variation in the extent of industrial action within as well as between boards. Any number of institutions within each board may be affected at any one time and different categories of ancillary worker can be involved at different times with numbers varying from just a handful to a few hundred while the work stoppages themselves have lasted from only a few hours to several weeks. To obtain the numbers of workers involved in all these industrial disputes has meant resorting to little better than guess work. In many instances part time workers have been involved which has made for problems in determining the number of working days lost in terms of 'full time equivalent' employment. Also the duration of industrial actions, while slightly easier to detail, has been of questionable statistical relevance. A strike of just three hours involving no more than about ten people cannot readily be scaled against one of three weeks where a few hundred are involved even if allowance is made for the large differences in the size of boards and their individual institutions.

In spite of the limitations pointed out earlier of just using the numbers of stoppages *per se* as the discriminating variable, this has been the only practical way for ascertaining the relative levels of militancy in the different boards. These levels of militancy are shown, as an 'index of class conflict' which comprises simply the number of work stoppages to have occurred and is shown, in table 9.4. The information has been presented spatially with reference to hospital board boundaries in figure 9.2 and all known work stoppages have been included whether or not related to contract employment. In view of the inherently unreliable nature of this exercise, the data can only be regarded as showing the crudest indication of the uneven spatiality of class conflict.

Work stoppages in public hospitals have occurred at two different spatial scales. The first are primarily local and regional based conflicts involving a particular hospital board or contractor and they are mainly related to disputes over work practices. The second occurs at the national scale and arises principally from breakdowns of annual Award negotiations over pay and employment conditions. In this second case, industrial action has been much more widespread than the first and not confined to any one hospital board.

The hospital boards in table 9.4 have been grouped into the two major categories of contracting out policy. Board size, as given by bed numbers, and indices of privatisation for 1981, 86 and 89 are also presented.

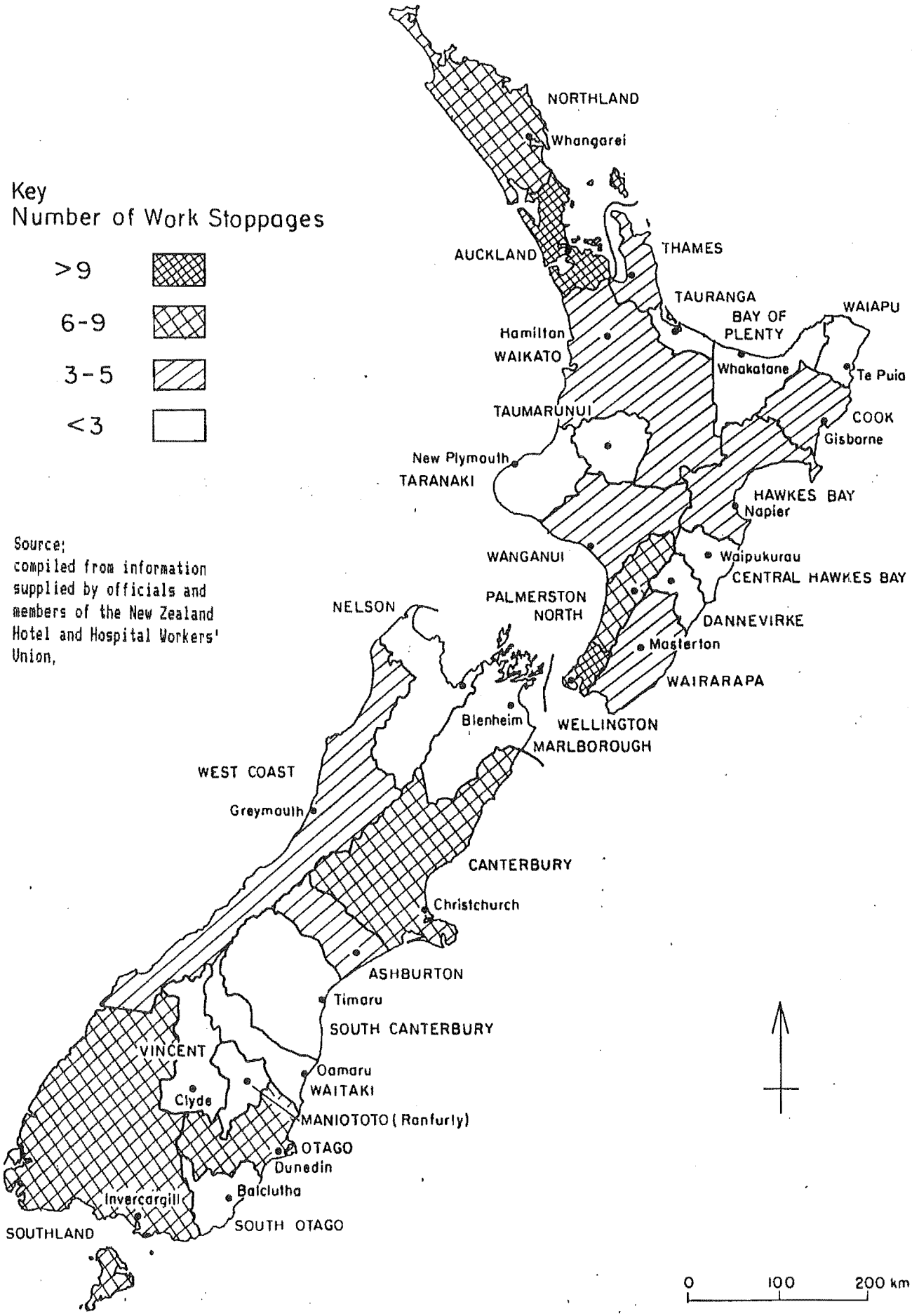
TABLE 9.4: Indices of Privatisation and Class Conflict

Hospital Boards	1989 Bed Numbers	Indices of Privatisation 1981	1986	1989	Index of Class Conflict
Commenced or Retained Contract Provision for Ancillary Services:					
Auckland	4,225	6.2	8.9	-	11
Canterbury	2,970	15.5	16.1	16.5	9
Otago	1,300	1.7	12.9	15.1	7
Waikato	2,457	12.0	11.8	12.6	3
Wellington	2,444	18.4	18.2	17.9	11
Hawkes Bay	716	27.4	27.4	26.8	3
Northland	780	66.7	100.0	66.7	6
S. Canterbury	488	29.2	29.6	29.6	1
Southland	731	61.6	93.2	93.7	7
Taranaki	634	27.0	27.1	28.5	2
Tauranga	386	62.2	62.5	62.3	2
West Coast	625	33.8	34.5	19.0	4
Ashburton	234	100.0	100.0	100.0	3
Bay of Plenty	247	95.0	95.3	97.6	1
Marlborough	185	61.1	61.3	63.3	1
S. Otago	134	-	68.1	64.2	2
Taumarunui	105	66.7	66.7	66.7	1
Thames	234	41.8	64.6	73.0	3
Vincent	67	100.0	100.0	100.0	1
Waitaki	185	-	50.2	50.5	1
Mean Level of Class Conflict (Labour Militancy)					3.9
Terminated or Refrained from Contract Provision for Ancillary Services:					
Cook	317	-	-	-	4
Nelson	958	-	-	-	2
Palmerston N	1,315	-	-	-	6
Wanganui	714	-	-	-	3
Dannevirke	114	66.7	-	-	2
C. Hawkes Bay	234	-	-	-	1
Maniototo	46	-	-	-	1
Waiapu	38	-	-	-	1
Wairarapa	275	-	-	-	3
Mean Level of Class Conflict					2.6

Source: Department of Health records and information supplied by regional offices of the New Zealand Hotel and Hospital Workers' Union

Figure 9.2

Regional Variations in Number of Work Stoppages in New Zealand Hospital Boards since 1970



Unlike the privatisation index established in chapter six, the militancy index has had to be given as an aggregate across time as work stoppages in many boards have been too infrequent to allow a meaningful index to be determined for each year under consideration. It may be seen immediately that all boards have recorded at least one stoppage owing to a national 24 hour strike, called in conjunction with nursing staff, in February 1989 over pay and conditions. In the following sections a more detailed analysis is made of the spatial and temporal growth of labour militancy and its relationship to contracting out.

9.2.2 The Growth of Industrial Militancy in the Ancillary Sector Workforce:

Comparing the two groups of contracting out policies, those hospital boards that dispensed with contractors around 1980, have shown a lower mean level of militancy, as a collective whole, than those that adopted the contract option. This is not particularly supportive of the hypothesis that high levels of class conflict inhibit privatisation although a *t* Test conducted on these mean values showed there to be no significant difference even at the five percent level. The situation appears slightly different when the index of class conflict is correlated against the index of privatisation.

For the years 1981, 86 and 89 respectively *r* values of -0.19, -0.14 and -0.20 were obtained. All are very low and statistically insignificant but nonetheless negative, indicating a slight tendency towards lower levels of privatisation where militancy is highest. The strongest correlation however was found between board size and militancy giving an *r* value of 0.82 on 1989 bed numbers. While this may partially be accounted for simply on the basis of there being more hospitals in larger boards and hence more opportunity for militancy, this factor can largely be discounted for two reasons. First is that where work stoppages have involved more than one hospital, this has only been recorded as one incident in the index of class conflict. The second is that work stoppages in large boards have tended to occur repeatedly in the same hospital. A more plausible reason for the high correlation is that the largest boards also contain the largest institutions and are centred on major urban areas where working class organisation tends to be stronger, compared to smaller institutions and rural settlements. But as chapter six showed, board size itself was not a particularly strong explanatory variable in the geogragraphy of contract service provision.

One clear factor to emerge from the data collection is that workforce militancy has been spatially variable and almost exclusively confined to the 1980s. Table 9.5 lists the major industrial confrontations

TABLE 9.5: Principal Work Stoppages in New Zealand Public Hospitals by Members of Hotel and Hospital Workers' Union

Hospital Board	Year	Staff Category	Employer at Time of Work Stoppage	Duration of Strike
Otago	1974	domestics	contractor	1 day
Otago	1980	domestics	hospital board	2 days
Wellington	1981	domestic	contractor	4 weeks
Auckland	1983	domestic	contractor	6 weeks
Various Boards	1985	all categories	State (Award Breakdown)	various
Wellington	1985	orderlies	hospital board	12 days
West Coast (Greymouth)	1985	domestic & orderlies	contractor	2 weeks
Northland (Whangerei)	1986	dietary	contractor	4 weeks
Palmerston N.	1986	domestic	hospital board	2 days
Ashburton	1986	orderlies	contractor	4 days
Various Boards	1986	all categories	State (Award Breakdown)	various
Various Boards	1987	all categories	State (Award Breakdown)	2 days
Various Boards	1988	all categories	State Sector Bill	1 day
Various Boards	1989	all categories (+ nursing staff)	State (Award Breakdown)	1 day

Source: Regional offices of the New Zealand Hotel and Hospital Workers' Union

that have occurred in public hospitals. Apart from a 24 hour strike in Otago in 1974, prolonged disruptions did not start until the early 1980s. A factor not so apparent from table 9.5 is that during the decade industrial disruption has tended both to intensify and to expand geographically in two important respects.

The first is that while industrial disputes over contracting out have predominated in the first half of the 1980s, the second half has seen the growth of militancy as a result of breakdowns in national Award negotiations. A consequence of this has been that the spatial extent of industrial disruption has increased in the second half of the 1980s since the cause has been at a national rather than local level. The result of this has been that many hospital boards in the mid and late eighties have seen industrial disruption in their institutions even though the workforce has not been employed by private contractors.

The second point is that with national Award breakdowns the form of industrial action has intensified insofar as it has had more serious affects on service provision. From being predominantly just 'limited action' in 1985 such as the banning of certain duties[5], the late 1980s have seen complete strike action in many, if not most, hospital boards. So while in the necessarily crude quantitative measures used here, labour militancy does not appear to have increased overall, empirical investigation reveals a distinct qualitative increase.

An explanation of the breakdown of Award negotiations needs to be set in the context of falling real wages in the hospital ancillary sector and the ever more restrained financial climate with the consequent difficulty of achieving pay settlements. Table 9.6 shows that, when adjusted for inflation, ancillary workers basic pay in 1989 was only 70 percent of that in 1981. Viewed spatially, the relatively higher cost of living, and hence lower real wages, in Auckland and Wellington compared to the remainder of the country, may explain some of the higher level of militancy in these boards. Be this as it may, a managerialist (Weberian) perspective on the process might have predicted a progressive spatial development of contracting out throughout the 1980s as a direct result of the increasing militancy.

Such a development has not occurred and, as the maps in chapter six show, there has since 1985 been a reduction, if only a slight one, in the spatial extent of contracting out. The negative correlation between levels of privatisation and labour militancy cited above rather conflicts with managerialist theories that predict greater privatisation with labour militancy in order for managers to rid themselves of industial relations

TABLE 9.6: Public Hospital Ancillary Workers Weekly Wages 1981 - 1989

Year	Basic Weekly Wage[1]	Average Annual Percentage Rise Consumer Prices[2]	Consumer Price Increases since 1981	Weekly Wage Increases since 1981	Weekly Wage Reduced to 1981
1981	193.56	15.4	1000	1000	1000
1982	211.43	16.1	1154	1092	946
1983[3]	211.43	7.4	1340	1092	815
1984[4]	219.43	6.1	1439	1133	787
1985	234.79	15.5	1527	1212	794
1986	282.03	13.2	1764	1456	825
1987	301.35	15.7	1997	1556	779
1988	322.44	6.8	2311	1665	720
1989	334.44		2468	1727	700

1 as per New Zealand Hospital Domestic Workers Award

2 as given in *New Zealand Official Yearbook*, various years and *Key Statistics*, Department of Statistics, February 1989

3 Wage Freeze from June 1982 to December 1984

4 Cost of Living Allowance of $8.00 per week as from 1st April 1984.

Source: calculated from data given in New Zealand Hospital Domestic Workers Award, *New Zealand Official Yearbook*, various years and *Key Statistics*, Department of Statistics, February 1989

problems. As was indicated earlier in the chapter, where there is major service disruption consequent upon industrial conflict this may inhibit privatisation and the analysis here lends some limited support to this contention.

Rather than contracting out being a result of militancy, the latter may be said to have been in part a consequence of the former which has been underpinned, as the last chapter showed, by the deteriorating socio-economic conditions of the 1980s. Paradoxically however it has been precisely in this most recent period that significant moves have been made to privatise other sectors of the public health system and the state sector in general. The issue to be decided then is what role has workforce militancy played in displacing the locus of contracting out policies away from the ancillary sector?

In certain cases there would seem to have been virtually no relationship between contracting out and work force militancy which may largely explain the weakness of the correlation between the two variables. The case study presented in chapter six showed that the termination of contract service provision in Maniototo as well as the permanent in-house provision in Waiapu certainly could be at least partly be explained on the basis of factors other than workforce militancy. Similarly the ending of contracting out in Wanganui, Palmerston North and Wairarapa took place before the advent of the union campaign against contracting out and the growth of union militancy. Although the contract provision in Dannevirke was terminated in 1985, a year of considerable militancy throughout the hospitals in New Zealand, there appears to have been very little disruption in that particular Board. In this case, according to the Board management, the change to in-house provision was made, like the others cases just cited, "*for reasons of both efficiency and cost saving*" (Dannevirke Hospital Board, written personnal communication, 20th September 1988).

To the extent that workforce militancy has influenced the contracting out process, it has perhaps been more as an inhibiting factor to its expansion rather than a mechanism for reversing the process once established. If the trade unions have not been able to 'clean out contractors' then at least they have not been 'cleaned out' by them. Numerous interviews with hospital board managers revealed the existence of two counterposing possiblities. On the one hand it was widely recognised that the ancillary service workforce has become much more militant of recent years while on the other hand the savings still to be made have become progressively less significant. This is especially so when viewed

in proportion to the highly increased levels of cost cutting required throughout all sectors of the hospital service at the end of the 1980s. Far larger savings may be made in other hospital services where the workforce is not so industrially militant.

> One hospital board manager made the illuminating comment that:
>
> If we contracted out the domestic services we could probably save around $50,000 a year - not worth it for all the trade union opposition that would follow. But if the saving was to be $500,000 then we would certainly think again (personnal communication 18th November 1988).

In some respects it could be argued that trade union opposition has been too little too late and, judging by the data illustrated in figure 9.2, possibly too spatially fragmented to have achieved the goal of completely cleaning out contractors. Yet insofar as the contracting out process has, temporarily at least, been halted then perhaps the campaign has been better late than never.

In order to gain a further insight into the uneven development of contracting out and the role of class conflict, it is instructive to make a comparative study of some hospital boards that have adopted opposing policies for ancillary service provision. Significantly lacking from the discussion of workforce militancy so far have been the examples of the Northland and Auckland Boards, both of which have terminated contracts, the latter all of them in 1988, and both having been the scene of major industrial conflicts. These two cases are considered further in the next section.

9.3 The Geography of Contracting Out and Class Conflict: Case Studies

To provide further understanding of the geographically uneven development of privatisation, it is worthwhile to compare the form of ancillary service provision in Northland and Auckland with the Southland and Otago Boards. Both Auckland and Otago contracted out their domestic cleaning services in 1981 and 1982 respectively and similarly Southland and Northland contracted out their dietary services in 1983 and 1985 respectively. While Otago and Southland have retained contract provision the other two reverted to in-house provision in 1988. The question then is why have the two northern Boards changed their policy and not the southern two? In the following section the relevance of some of the explanatory factors advanced in earlier chapters in respect of geographically uneven privatisation is discussed prior to analysing the significance of labour militancy in these examples of contracting out.

9.3.1 Statistical Comparison of Northland with Southland and Auckland with Otago Hospital Boards:

When comparing Northland with Southland and Auckland with Otago, a number of similarities emerge in terms of gross characteristics like bed numbers, board district and main city populations and accessibility from major urban centres. Although the population and bed numbers of the Auckland Board are much greater than Otago, compared to other boards in the country these two are in the same size category in as much as they each have over 1,000 beds, offer highly specialised services and have medical schools. The main urban settlements in Northland (Whangarei) and Southland (Invercargill) are each of similar size and travelling distance from principal urban centres of population; respectively Auckland and Dunedin. Table 9.7 presents these gross characteristics in tabulated form. From this it should be clear that very little explanatory value for uneven development of contracting out can be placed on institutional (scale economies) and locational (accessibility and investment opportunity) factors which were considered in chapter six.

TABLE 9.7: Comparative Data on Four Hospital Boards with Diverging Contracting Out Policies 1988

Hospital Board	Principal Urban Centre	Beds Numbers	Board Population	Population of Urban Centre	Accessibility
Auckland	Auckland	4,355	913,500	820,754	-
Otago	Dunedin	1,317	121,300	106,864	-
Northland	Whangarei	827	129,600	44,043	3hr 00m (171km)
Southland	Invercargill	731	116,000	52,807	3hr 10m (217km)

Data Source: *Hospital Management Data*, 1986 Census, and Department of Health

A similar lack of explanatory significance holds in respect of the relative degree of financial constraint on the Boards. In the most recent census year (1986) the operating grant per capita, with allowance for cross boundary population flows, for Auckland ($325.7) was considerably lower than for Otago ($433.7) while Northland and Southland had fairly similar levels of financial constraint; $347.5 and $336.8 respectively (see chapter eight, table 8.2). As Otago was less financially constrained than Auckland, the termination of contracting might more readily be expected in the former rather the latter Board.

With reference to the concept of cost effectiveness this can be understood here not only as service costs per bed, as in chapter eight, but also in terms of contract staff numbers per bed since data on the latter quantity is available since 1984. In table 9.8 comparative data on cost effectiveness between the boards is presented based on the hospitals and services where contract service provision obtained. It can immediately be seen that in 1988, the year of contract termination in Auckland and Northland, services were less cost effective than in either Otago or Southland for both staff and costs per bed.

Viewed over time the situation is not so clear cut. As the dietary contract in Northland only commenced in November 1985 which was the 1986 financial year, it has not been possible to ascertain the relative cost effectiveness with Southland over a meaningful time period. With Auckland however contract staff numbers per bed have remained fairly constant over the period 1984-88 whereas in Otago they have decreased from 19.6 per 100 beds to 14.8 per 100 beds. Considering Auckland's consistently greater staffing levels than in Otago it is perhaps surprising that their costs per bed are the lower of the two in 1984 and 1986. In such labour intensive industries changes in staff numbers might reasonably be expected to parallel changes in service costs. Yet whatever the contradictory nature of the data there is then little substance to the argument that by 1988 the contractors had cut the staff level and service costs to an irreducible minimum in Auckland and Northland so that the only savings to be made were on the contractor's overheads and profit.

A further factor that can be ruled out as an explanatory variable in these cases is that of the professionalism and skill acquisition of the ancillary workforce since these requirements vary between sectors of hospital services and not regions. Consequently, institutional, locational, financial and professional considerations cannot be invoked in attempts to explain the adoption of different forms of service provision in 1988. This only leaves the managerial and political factors discussed in the previous chapter together with the difficulties in industrial relations. These are discussed in greater detail in the following sections, starting with the latter, if only because they provide the most striking contrast between the two southern and northern boards.

9.3.2 Labour Force Militancy in Auckland and Northland: the Implications for Contracting Out:

The higher levels of industrial disruption in the ancillary services of the Auckland and Northland Boards provide an immediate point of contrast with Otago and Southland. At first sight this contradicts the

TABLE 9.8: Comparison of Cost Effectiveness in Contract Service Provision between Auckland and Otago and Northland and Southland Hospital Boards

	HOUSEKEEPING Services		DIETARY Services	
1988	Auckland	Otago	Northland	Southland
Contract Staff in FTEs	146.5	61.5	89.8	42.2
Total Contract Cost in $	3,140,409	1,838,530	2,049,009	1,372,627
Average Occupied Beds	664.2	415.3	597.8	497.1
Contract Staff per 100 beds	22.1	14.8	15.0	8.41
Contract Cost per bed in $	4,728.1	4,427.0	3,427.5	2,761.3
1986	Auckland	Otago	Northland	Southland
Contract Staff in FTEs	188.0	61.5	Board Provision to November 1985	
Total Contract Cost in $	2,653,671	1,191,268		
Average Occupied Beds	895.2	362.8		
Contract Staff per 100 beds	21.0	17.0		
Contract Cost per bed	2,964.3	3,283.5		
1984	Auckland	Otago	Northland	Southland
Contract Staff in FTEs	161.9	80.1	Board Provision	
Total Contract Cost in $	2,225,476	1,389,922		
Average Occupied Beds	727.8	408.2		
Contract Staff per 100 beds	22.2	19.6		
Contract Cost per bed	3,057.8	3,405.0		

Source: calculated from data in *Hospital Management Data*, 1984, 1986 and 1988.

index of labour militancy, admittedly oversimplified, shown in table 9.4, in which Northland and Southland appear to have had roughly equal number of work stoppages. The situation becomes clearer upon realising that Northland, as well as Auckland, were the scenes of two highly protracted work stoppages, the significance of which is not adequately portrayed in simple enumeration. At the end of 1983 there was a six week strike of domestic cleaners employed by Crothalls Ltd at Auckland Hospital and, in early 1986, one of four weeks duration, preceeded by nine weeks of limited industrial action, by dietary service workers employed by Advanced Food Services Ltd in all the hospitals in the Northland district.

By comparison the industrial scene in Otago and Southland has been characterised by disputes of a much smaller scale both in terms of duration and numbers of workers involved. While limited industrial action was quite extensive in Otago by the workers under contract employment, (*Otago Daily Times* 26th June 1984 and 3rd September 1985), no prolonged disruption occurred in either Board, with complete stoppages (ie strikes) being restricted to just a few days at the most. In the Southland Board strikes were sometimes just confined to workers on one particular shift rather than all within the entire service. So while there was certainly resistance to the conditions of work under contract employment, particularly in Otago, the campaign appears to have been less intense than in Auckland and Northland.

In Auckland the domestic cleaners' strike began after the contract had been in operation for 27 months and staff numbers had been reduced from 182 at the commencement of the contract to 105 (Hotel and Hospital Workers' Union circular to all affiliates, no date) while Crothalls cited a reduction to 102 although no independent verification of any of these figures was available. The company justified this reduction on the grounds that, "*the productivity rate of the Auckland Cleaners is lower than that which exists in our other 46 contracts*" (Crothalls circular letter to all hospital boards, 22nd November 1983) but no indication was presented as to how the productivity rate was calculated.

The prime reason for the strike was in order to achieve increases in staffing levels to combat falling service standards and increased workloads since attempts to realise this through negotiation were seen by the union to have failed (Union circular to all affiliates, no date). After six weeks the Government intervened with the Minister of Labour ordering a compulsory conference under the mediation of an industrial conciliator. After two days of deadlocked negotiation, the conciliator ordered the strikers back to work with the condition that Crothalls had to employ an

extra six workers and replace one who had left (*SHIFT* 1984, 3). The strike therefore simply altered, as was intended, the conditions of service provision rather than the form of provision, and another five years elapsed before the contract itself was terminated.

The cause of the industrial action in Northland was mainly over the principle behind the letting of the contract for the dietary services without there being any prior consultation between the workers involved and the Northland Area Health Board. Rather than specifically seeking an improvement in the conditions of employment, the strike was more in anticipation of reduced staffing levels and lower standards of service provision under contract. The prime purpose of the strike was to have the contract cancelled and a return to service provision by the Board. The strike itself had been preceded by a period of limited action from 18th November 1985, the date of commencement of the contract, to January 19th 1986 (9 weeks) after which there was a complete work stoppage to the 15th of February 1986. Shortly prior to the end of the strike, a meeting between the Hotel and Hospital Workers Union, the Federation of Labour[6] and the Employers' Federation proposed that a committee of enquiry be formed to investigate the way in which, "*the contract was let, the lack of consultation* [with the union] *and the appropriateness of the contract*" (*SHIFT* 1986a, 11). On this basis a High Court injunction was issued ordering a return to work. The strike however did not succeed in terminating the contract and instead the formation of a committee of enquiry was the immediate outcome.

These major strikes were only the most visible part of trade union campaign against the contractors in these two boards. Apart from these there were also, in the case of Auckland at least, numerous strikes of shorter duration while in Northland workers adopted, "*a non-cooperation attitude to the contractors*" (written personal communication from Hospital Workers' Union, 10th August 1989) which meant, for example, that workers would collectively refuse to undergo changes to their hours of work, the areas in which they were to work or the duties required of them. Figure 9.3 exemplifies some of the strategies adopted in the 'non-cooperation' campaign. The effect of this was that, "*no moves could be made by AFS to implement changes which would result in profit making for the company*" (written personal communication from Hotel and Hospital Workers' Union, 10th August 1989). Similarly in Auckland, non-cooperation strategies made it very difficult to implement all the cost cutting measures deemed necessary by the contractor. For example Crothalls cite the case of night workers being unwilling to transfer to day shift and, "*all pressures we*

FIGURE 9.3: Trade Union Activity in the Work Place

NOTICE TO MEMBERS

DO NOT AGREE TO CHANGE

YOUR HOURS

THIS IS A move TO
Reduce Staff NUMBERS

DONT BE A PARTY TO
Somebody else losing
Their job!!!

Always have a Delegate present when called into the Office - for your protection - and your jobs!

Source: Northern Hotel and Hospital Workers' Union

have applied to move this group have met with union involvement by way of support for their members" (Letter from Crothalls to Auckland Hospital Board, 6th October 1982).

The central question then is to ascertain the precise linkage between the industrial disruption that took place and the action of the two Boards in terminating the contracts. As was detailed in chapter five hospital and area health boards comprise both a management (appointed) and a membership (elected) structure. The respective roles played by these structures in the reversion to in-house provision must also be examined in the context of the trade union campaign. In the next section the attitude of hospital management staff in Auckland and Northland is considered and, where appropriate, comparisons are drawn with the Otago and Southland Boards.

9.3.3 The Management of Ancillary Services in the Auckland and Northland Boards:

In the light of the intense industrial disruption with contract services, reversion to Board provision counters any theory of 'bureaucratic rationalisation'. It might therefore be expected that the Boards' management staff would be highly opposed to such a move but from the proposals made by the management to the Board members this was not case. According to the available records, in all three hospitals in the Auckland Board where contractors were engaged - Auckland, North Shore and Sutherland, the respective hospital managers advocated the termination of the contracts in their reports to the Board membership. The justification presented for recommending the termination of the contracts was based primarily on the inadequacy of standards of service provision and the costs involved with this form of provision.

Of the three contractors who submitted tenders for Auckland Hospital in 1987, two were thought by management to be insufficiently resourced to ensure an adequate and reliable service. The third contractor, which was the incumbent Crothalls, was deemed to have submitted the most realistic tender and the company cited three possible options for the Board, the most economical of which required the elimination of rotating shifts. In an internal memorandum of 11th November 1987 from the Executive Officer, Hotel Services to the Board's Chief Executive, it was written, "*Such changes may cause adverse reaction from staff, it would affect thirty nine people, possibly creating more industrial action*" (my emphasis). This point however was not made in the report to the Board membership. Instead the management submitted a proposal detailing how the service could be provided more economically in-house. This would be achieved by reducing what were thought of as the contractor's excessive allowances for, "*sick*

pay, annual leave and the miscellaneous insurances" (Management Report to Auckland Hospital Board, 30th November 1987).

In spite of the formal justification for contract termination on financial grounds, the possibility of further industrial disruption and consequent suspension of service appears an important factor in the recommendation of in-house provision. For both North Shore and Sutherland Hospitals the stated reason in Board reports for reverting to in-house provision was based more on poor standards of service rather than industrial action. North Shore management reported that, "*The present staff of approximately 23 full time equivalent persons is barely adequate to maintain a satisfactory cleaning standard* (Management Report to Auckland Hospital Board, 16th March 1987), but also mentioned was that the Hospital Workers Union, "*has indicated its willingness to cooperate closely with the Board, to ensure the maximum possible flexibility, effectiveness and efficiency*". The clear implication is that the workforce did not cooperate closely with the contractor and this doubtless adversely affected the standard of service.

For the Northland Board, the management argued that, by terminating the dietary service contract, cost savings would arise:

> through not having to pay a salary for the Base Hospital food services manager ($36,500 pa), a pay clerk's salary ($20,000 pa) and an estimated profit of $104,000 pa, [and] elimination of excess wastage of food would result in savings of at least $94,000 per year. (Management Report to Northland Area Health Board, 3rd October 1988).

Significantly, however, the Board minutes also made the following observation in support of the termination of the contract:

> The Personnel Manager has commented that the Board spends more time settling kitchen labour relations issues than it does for any other section of Board staff, and in the event of strike action it has been the Board's staff who have taken total responsibility for organising volunteers (Management Report to Northland Area Health Board, 3rd October 1988).

Even more pertinent however to the termination of the contract, and confirmed from discussion with Board management, was the agreement of the trade union to end its non-cooperation policy. A written communication of 7th October 1988 from the Hotel and Hospital Workers' Union to the Northland Board General Manager highlights this point and is quoted at length in view of its importance:

> The situation should Advance Foods be contracted to continue to run the kitchens in Northland will mean that previous agreements made between that company and this union would prevail. These agreements thrashed out during the period of that dispute are quite clear in guaranteeing the continued privileges of all those workers in respect to rosters, the ability to maintain their

> level of earnings and the other conditions they had enjoyed whilst employed by the Area Health Board previously. We believe, having discussed with those members the current situation, that they have much to offer the Board in the way of efficiencies and economies for the future. That level of co-operation would be available should the Board decide to take back the employment of our workers.
> Should, however, the contract go to Advanced Foods or any other contractor, clearly that level of co-operation from those members would be very difficult to deliver.

This passage and the earlier quotes makes clear that while economic (ie cost savings) or managerial (ie standards of service) arguments could be presented for terminating contracts, underpinning both of them was the desire by the Boards to end industrial disruption and gain workforce co-operation. With the case of Auckland however a further factor to be considered in the contract termination was the workforce involvement with the elected Board membership. Curiously this involvement went much further in Auckland than Northland to say nothing of Otago and Southland.

9.3.4 Political Factors in the Termination of Contract Services in the Auckland Hospital Board:

The composition of the Auckland Hospital Board has been unique in New Zealand through the election in 1986 of members of a Community Health Coalition. This was specially formed in, "*an effort to get worker representatives onto the Hospital Boards throughout the Northern Region* [of the Hotel and Hospital Workers Union]" (*SHIFT* 1986b, 5). The policy was largely born of a view held by many trade unionists that existing hospital board members had very little interest either in maintaining a comprehensive public health system or in the employment conditions of many of its workers, particularly in the face of mounting pressures to expand privatisation policies in all other areas of the hospital service. Such a view is given at least indirect support from Baker (1988) as discussed in the previous chapter.

According to *SHIFT* (1986c, 7), the newspaper of the Northern Region of the Hotel and Hospital Workers' Union[7], the main aims of the Coalition were, "*to support a free, public health system and to elect people to the board who are prepared to pressure local government to ensure this happens*". More specifically a major concern of the Coalition was, "*the way staff are treated at the hospital - orderlies, domestics, kitchen workers and nurses do not get a good deal*". The removal of contractors from the hospital system was clearly a principal objective as evident from the campaign literature distributed to the workforce. As the placard depicted in figure 9.4 makes clear, "*We want contractors OUT of our health system*" (*SHIFT* 1986c).

FIGURE 9.4: Trade Union Campaign for Election to the Auckland Hospital Board

Hospital Workers

it's time to get on the

Hospital Board

We are sick of the way we are treated.
We want a free, public health system.

We want to see domestics, orderlies, kitchen staff and nurses treated fairly.

We want contractors OUT of our health system.

It's about time WORKERS were represented on the board.

Source: *SHIFT*, April/May 1986

Of the eight people who formed the Coalition, four gained seats on the fourteen person Board in the October 1986 election. The Board itself was structured into six committees of which the Finance and General Purposes Committee was the one which handled issues related to contract service provision and received reports from the Board management staff on this issue. Six people served on this committee, two of whom were from the Community Health Coalition and one of these was a member of the Hotel and Hospital Workers Union employed at Auckland Hospital. All policy decisions had to be approved by this committee before being passed by a full meeting of all Board members. The Coalition members were not therefore in a majority position on this committee but certainly had a platform from which to make their views known and to present arguments for termination of the contracts.

As seen above the reports from the Board management recommended, even if not particularly persuasively, that in-house provision be reverted to. It is hardly surprising then that the contract was terminated. Nevertheless it is clear from the arithmetic of the Board membership alone that the four other members of the Finance Committee, none of whom had any trade union connection, could have out voted the two from the Coalition and overturned the management's recommendation had they been so inclined. An argument that the changed form of ancillary service provision in Auckland was purely the result of the election of a special interest group cannot readily be sustained although this was undoubtedly an important factor.

To summarise the situation, three factors seem to have operated in conjunction with each other in securing the termination of the Auckland Board contracts. First has been that of a militant, organised workforce likely to create further service disruption if placed under greater pressure from the contractors. The prospect of greater industrial tranquility therefore made a return to in-house provision look more attractive from a management perspective even if difficult to justify financially. The second factor then has been a management structure prepared to undertake further administrative responsibility albeit with a guarantee of workforce co-operation and a less traumatic climate of industrial relations.

That a satisfactory standard of service provision could not possibly be achieved from the staffing level, when under contract, is not readily indicated from the data given above on cost effectiveness in Auckland (and Northland) compared with Otago (and Southland). A more plausible argument is that the union non-cooperation strategies detailed earlier have inhibited the attainment of production levels sought after by the

contractors (and the Board) to the extent that further attempts to make such gains would have seen even more industrial disruption. Whether this is seen in terms of a class conflict in which workers struggle to retain their rights and conditions of employment or as merely union intransigence towards greater efficiency depends entirely upon the conceptions of the public interest which was discussed in chapter one.

The third factor involved comes from the observation that neither the workforce, no matter how militant, nor the management, no matter how firm in their policy proposals, have the final say in policy decision making. This duty falls to elected members of the Board. To this end the gaining of political power by workforce representives has been an important factor in bringing about the end of contract service provision. Yet this political power has only been founded on the basis of on going class struggle in the workplace. None of the three factors just cited here has operated so forcefully in Otago and Southland where, by contrast, the industrial disruption was less protracted although by no means non-existant. There were no worker representatives elected to either of these two Boards and no management proposals advanced for contract termination.

Conclusion:

In this chapter the effect of class conflict (or labour militancy) has been assessed for its part in the geographically uneven development of private contracting. Its mediating role would seem to have more explanatory potential when viewed temporally rather than spatially since increasing militancy by workers, and financial restrictions on hospital boards in the 1980s, has not seen a growth in contracting out as public choice and managerialist theories might predict. Instead strong workforce organisation has managed to halt, if not entirely reverse, the process. In terms of the spatial dimension, the role of class conflict is less clear cut. Contracts have been terminated in places where clearly labour militancy was not an issue.

Even where the work force is industrially strong, as in the above examples, the reversion to in-house provision has required a major electoral campaign as well as an industrial one. The role of elected bodies in determining patterns of resource allocation cannot therefore be held as insignificant as a crude Marxian perspective might suggest. On the other hand any theoretical explanation of uneven privatisation which neglects the role of the class forces at play would be equally remiss.

To locate explanations for privatisation in terms of over powerful trade unions, as is the tendency in public choice theories, is to ignore the contradictory aspect of the process. As this chapter has shown, a

militant unionised labour force can inhibit, and occasionally even reverse privatisation policies. But this in no way means that the employment conditions of ancillary workers then cease to be subjected to further pressures. In the next chapter, which forms the concluding one of this thesis, the theoretical frameworks for explaining privatisation are reexamined in the context of both the uneven development of private contracting, as detailed in this study, and some of the current changes in hospital service provision as they affect the ancillary sector workforce.

Footnotes:

1 The Hotel and Hospital Workers Union exists as eight regionally autonomous units. Besides public hospital ancillary workers the Union also represents, the same category of workers in private hospitals and rest homes, boarding houses, hotels, motels, resturants and tearooms. At a national level, the eight regional units are amalgamated with the Cleaners and Caretakers Union and together comprise the Service Workers Federation of Aotearoa (New Zealand).

2 In New Zealand employment conditions are set either by an Award or an Agreement. The former is industry based and applies to all workers within that industry regardless of geographical location. An Agreement however is site based and only applies to workers on a particular site. There would then be considerable geographical variations in conditions obtaining under different site agreements.

3 This condition does not extend to workers in private hospitals who, while being in the same trade union, are covered by a different Award in which the basic pay rate is lower than in the public hospitals. Workers in Rest Homes are on yet another Award with still lower rates of pay. In June 1989 the following basic weekly (40 hours) pay rates obtained for, domestics (cleaners), kitchen hands, and orderlies:

Public Hospitals	$334.44
Private Hospitals	$326.02
Rest Homes	$308.60

4 In New Zealand, all visits to General Practioners, while subsidised by the Government, have to be paid for by the patient at rates of between $20 and $30 per consultation at 1989 prices.

5 Work stoppages are forms of industrial action which can be classified in two ways; complete and partial stoppages. The former refers to strike action (ie the withdrawl of labour from the productive process) while the latter means the banning of certain duties normally required of the workforce and is generally termed, 'limited industrial action'.

6 The Federation of Labour (FOL) together with the Combined State Unions (CSU) were two umbrella organisations which between them spoke collectively for the New Zealand trade union movement. In 1987 the two amalgamated to form the Council of Trade Unions (CTU).

7 In addition to *SHIFT* there are two other newpapers issued by the Hotel and Hospital Workers Union which together deal with all regions of New Zealand. *PUSH*, issued by the Wellington branch of the Union, covers the lower part of the North Island while the whole of the South Island is covered by *HOSP* produced by the Canterbury Branch.

CHAPTER 10

The Geography of Privatisation and the Provision of Public Hospital Services in the 1990s: A Reconsideration of Theory

There are two main purposes to this final chapter. The first is to summarise the findings of the empirical research conducted in this thesis and to assess the explanatory powers of the theoretical frameworks that have been used throughout. The second is to draw some conclusions on the relevance of the mode of geographical enquiry adopted here for further research. Parallels are drawn with some recent work in the field of regional and locality studies, and the contribution of the thesis is examined in the light of this work. To illustrate the theoretical contribution of the thesis, some contemporary developments in the privatisation of public hospital services are discussed in the context of the previous empirical research.

The chapter is presented in six parts. The first details the explanatory factors identified in earlier chapters as being responsible for mediating the uneven development of privatised hospital ancillary services. In the second part an attempt is made to set these factors into the theoretical frameworks of the thesis. The third part begins to address the second issue of concern to the chapter and starts by examining the limitations of trying to apply these frameworks in the given empirical case study. These limitations notwithstanding, the contribution of the research towards understanding the on-going developments in the privatisation of public hospital care forms a fourth part to the chapter. In the fifth section some of the theoretical insights gained from the thesis are illustrated in a short account of the likely future development of public service provision under conditions of increasing state fiscal stress. The concluding section outlines some future avenues for geographical enquiry in the light of the research undertaken here.

10.1 Empirical Factors Mediating the Development of Privatised Service Provision:

Throughout the discussion on the uneven development of privatisation in the preceeding chapters, a number of empirically observable factors have emerged as offering a measure of explanation. Eight have been identified and can be classified as:

1 Institutional

2 Locational

3 Professional

4 Managerial

5 Financial

6 Political

7 Industrial

8 The socio-economic context

All of them vary in importance across space and time and each is considered in order.

1 Institutional: variations in the size of institutions, such as hospital boards and individual hospitals, has clearly affected the spatiality of contracting out. The desire to achieve scale economies in production has led to contract provision in the smaller rather than larger institutions. Hospital boards which have not been of sufficient size to merit the employment of managers specifically for ancillary services have found it administratively advantageous to contract out. On this basis it has been possible to explain the (slightly) greater degree of contract provided ancillary services in the smaller hospital boards.

2 Locational: the relevance of the spatial location of an institution to contracting out for its service provision is reflected in the physical accessibility to contractors and the existence of a competitive market environment. Consequently contracting out becomes economically disadvantageous in remote geographical locations. Most of the institutions in these locations are also very small and so on the basis of size alone would be expected to contract out. The locational factor therefore has worked in a countervailing direction to what the institutional factors based on scale economies indicate in respect of privatisation.

3 Professional: a distinct variation usually exists between the sectors of any industry in the levels of formally recognised skills and qualifications possessed by the workforce and management. The greater the degree of skill, expertise or professionalism, the more likely personnel are to have a much more powerful position in the bureaucracy compared with those in what are commonly regarded as unskilled occupations such as cleaning and orderly work. Contracting out of hospital ancillary services has therefore been implemented far more extensively in the least skilled sectors where there is not the same opportunity for control of resources by the personnel employed. The greater degree of professionalism involved in dietary and, to a lesser extent, laundry services largely explains their lack of privatisation compared to the cleaning and orderly services.

4 Managerial: by privatising a service, managers are relieved of the administrative burden that is entailed in its provision. In times of economic expansion the hospital boards in regions with the greatest labour shortage tended to opt for contract provision to rid themselves of staff recruitment and retention difficulties. In recessionary times however

contracting out was resorted to to dispose of the problems arising from the likely deterioration in industrial relations brought about by the need for greater cost effectiveness in service provision. This often cited claim by hospital boards was somewhat belied by the observation that regions with the most labour militancy did not exhibit the highest levels of privatisation.

To some degree the managerial factor coincides with the professional one since some professionally qualified staff also have managerial functions. A separation of the two factors is merited on the grounds that managers necessarily have an administrative function in the bureaucracy in a way that many professionals do not have. The latter, whether dietitians, nurses or technicians, form a distinct part of the hospital workforce in a way which those in a purely administrative role (ie managers) do not.

5 Financial: the greater the degree of cost savings an institution has to make, the more likely it is to contract out a service with the spatial variations in the extent of the process reflecting different levels of financial constraint. This observation has found some empirical support in this case study in as much as service provision only came to be seriously reassessed with increasing financial restrictions on boards. Those boards that contract out have generally been under greater financial constraint than those that have not. However no convincing evidence was found to substantiate the claim that boards under the greatest (or least) financial constraints showed the greatest (or least) levels of privatisation. The financial factor has had more explanatory value in determining the development of contracting out over time rather than in identifying purely spatial variations in the process.

6 Political: the spatial extent of privatisation should reflect variations in the political composition of different elected public bodies such as hospital boards. The election of conservatively minded officials could be expected to initiate a trimming down of the size of the public sector and the associated costs involved in favour of private provision. The lack of partisan based elections to hospital boards has prevented any empirical verification of this contention. Only in the case of Auckland in the latter half of the 1980s did pluralist politics play an obvious role in changing the form of service provision but even then industrial and managerial factors were found to be equally, if not more, important.

As far as could be ascertained hospital boards exhibited a degree of political uniformity across space and time. This very uniformity, though, considerably affected the sectoral variations in contracting out. A social class difference was found between the workforce in the ancillary

services and those members of the public elected to political power. In areas of hospital activity outside of the ancillary sector, the greater levels of staff professionalism involved has meant that the class cleavage with the elected bodies is not so marked. Consequently less political pressure has existed for privatisation in those areas compared with the ancillary services, particularly the cleaning and orderly sectors.

7 Industrial: the existence of a particularly militant and trade union organised workforce has manifested itself in two principal ways. Either hospital boards have been inhibited from adopting any privatisation policies or, where privatisation has been implemented, service disruption occurred to the extent that contract provision became neither economically worthwhile nor administratively practical. Both these findings contradict the managerial factor as a rationale for contracting out. In the latter case militancy induces contracting out, in the former it inhibits it. A critical factor to emerge from the study is that the magnitude of labour militancy is all important in influencing the form of service provision. Limited and sporadic industrial action which may be of little more than 'nuisance value' to hospital managers can satisfactorily be left to private contractors to handle. Where there is major and prolonged industrial action with service provision seriously compromised, managers can no longer delegate their responsibilities to outside contractors. There arises therefore an arbitary and undefined 'threshold' between provoking and preventing privatisation.

8 The Socio-Economic Context: the overall growth of the national economy has had an integral role to play in the development of contracting out in times of both economic expansion and recession. In the former case labour shortages often resulted in the introduction of private provision while in the latter, the increasing fiscal stress of the state (government), reflected in the reduced funding of hospital boards, produced a pressing need to reassess the form of ancillary service provision. When labour was scarce it was necessary to make optimal use of it by maximising service cost effectiveness. In the converse situation, when labour was plentiful, it was also necessary to make optimum use of it because then finance was scarce. It is noteworthy that two very different sets of macro economic forces have produced the need for the same result; more cost effective service provision.

Having summarised the empirical findings of the research the next issue is to relate them to the theoretical frameworks of the thesis. Without rehearsing the basis of these theories which were presented in chapter two and three, it may be noted that they posit respectively the

processes of pluralist politics, bureaucratic rationalisation and class conflict as being the critical explanatory variables in the privatisation of service provision. Geographical variations across space, time and service in the development of privatisation should be a reflection of changes to these processes.

10.2 The Contracting Out of Hospital Services within a Theoretical Perspective:

At least four of the eight explanatory factors identified above readily come within a Weberian managerialist framework of bureaucratic organisational theory. These are the institutional, the locational, the professional and the managerial factors. In the case of the first two, private contracting may be either adopted to achieve scale economies on account of institutional size, or on the other hand, rejected because of contractors' high overhead costs due to remoteness of location. Contrary to much contemporary public choice literature, which argues that public sector bodies are inherently inefficient, the citing of institutional and locational factors shows that, on economic grounds alone, privatisation is not always indicated.

The Weberian contention that bureaucratic (public) provision can be both rational and efficient, and therefore in the public interest, finds justification in this study. Structural limitations have been seen on the possibilities for both internal (public) and external (private) provision. If private is understood as simply 'external' provision and public as 'internal' provision then even in a comprehensively socialised economy there would still need to be a varying mix between the two forms of provision depending of the balance of institutional size and spatial location factors. Contracting out would still exist in such an economy even though it would not then be private contracting.

The dominance of professionals in bureacracies was very much a concern of Weber on account of the knowledge they possessed and the power this gave them to influence managerial decisions. Insofar as allocation by market forces, rather than by bureaucratic control from professionals, would threaten the dominance of the latter, privatisation in the case of hospital services has tended to occur most extensively in the services involving the least degree of professional qualification. This explanatory framework though is also echoed in public choice theory which argues that professionals, and indeed managers as well, will over supply outputs to maximise their status and/or budget within the bureaucracy. The Weberian framework however justifies the professional dominance on the grounds that the services concerned are critical to patient care and cannot

be left to the vicissitudes of the market place. Here public provision has a distinct (Weberian) rationality to it even if it is not necessarily efficient by the criteria of public choice theory.

In terms of specifically managerial factors, the Weberian approach argues that managers privatise their operations to ease administrative burdens. This again can be seen as a rationalisation process and it can be argued that hospital managers exhibited very little reluctance to contract out services in view of the problems it would relieve them of. By contrast with the predictions of public choice theory, all initiatives to privatise ancillary services came from managers themselves rather than from some external body insisting that the managers implement the policy. The results of this research provide substantial support for this argument and parallel the findings of Ascher (1987) in her study of contracting out in the UK.

The role of financial considerations in the uneven development of privatisation can be placed more readily within public choice theory. In the public economy variant of this theory, state sector managers, being 'maximisers', rather than 'satisficers' as in Weberian managerialism, will not privatise services unless obliged to do so either by political or financial pressures. Some support for this argument could be found on the basis that contracting out hospital ancillary services only came to be seriously reassessed when financial restrictions started to be applied to hospital boards. But as just seen managers saw privatisation as a ready solution to the problems brought about by greater financial constraint rather than an attack on their status within the bureaucracy. They did not therefore oppose the process.

Invoking the role of political factors as explanatory variables needs to be set in the context of all three theoretical frameworks. The particular framework selected depends heavily upon whether the conception of politics employed is based on the operation of democratic electoral procedures or on social class forces. In the former case, pluralist public choice theory argues that voter preferences, taken as being a surrogate of consumer preferences and the public interest in general, will pressurise managers into trimming the size of their administration and levels of service provision. Alternatively public demand for higher levels of services than what the market would supply should see pressure on bureaucracies to take over the provision themselves. It has already been seen in the previous section that this framework had little explanatory significance in the case study undertaken here.

In the Weberian perspective bureaucracies are dominated by

appointed managers and formally qualified professionals resulting in a social class difference between this group and the ancillary workers employed. The former group is therefore able to exercise a degree of political power over the latter. As already seen this provides at least part of the explanation for the sectoral uneveness of contracting out hospital services. Contracting out ancillary services is a means by which managers and professionals exercise their political dominance within the bureaucracy.

In many respects the Marxian framework of class politics differs little from this Weberian concept. The knowledge and skills of the professionals gives them a control over productive processes and the workforce involved while they themselves do not have any economic ownership of the resources to be allocated. As to whether this theorisation falls within a Weberian or a Marxian framework depends largely upon how liberally the concept of productive assets is applied; whether strictly to physical assets such as plant and equipment or to more nebulous forms such as the educational qualifications possessed by managers and professionals. Regardless though of which theoretical framework is invoked, political considerations do not provide much insight into the spatial or temporal development of contracting out as revealed in the case of hospital services.

The operation of industrial factors, by which is meant the labour militancy or class conflict engendered in the opposition to privatisation, can be set in a Marxian framework much more clearly than the political factors just discussed. Here the focus of privatisation is centred in the sphere of material production rather than in market exchange relations (ie cost savings) or electoral political considerations (ie consumer preferences). The level of class conflict is posited as being a retarding factor in the development of privatisation and works in opposition to the managerial factors. Through effective organisation aimed to preserve working conditions, an attempt to raise productivity can be resisted. This resistance will likely involve service disruption and threaten the profit margins of the contractor making private provision economically unviable.

Finally the role of socio-economic factors in the development of privatisation is another issue which can be analysed in terms of more than one theoretical framework. The contradiction engendered in increasing consumption of public services on the foundation of a narrowing economic (productive) base is recognised in the methodology of both public choice and Marxian political economy. The former cites demand for public services outgrowing the supply of resource while the latter is based on the

class antagonisms engendered in capitalism. The difficulty with these explanations as they stand is that they do not account for why privatisation first developed in times of economic expansion when there was neither state fiscal stress nor labour militancy.

At that time the key factor was the shortage of labour brought on by economic expansion. Apart from implementing mass immigration policies to increase the labour supply, a requirement for sustained expansion in such a situation is to make optimum use of the available labour supply. Within Marxian methodology this means maximising labour exploitation to increase capital accumulation and contracting out is a means of realising this goal. A Weberian approach would cite the need to relieve public bureaucracies of administative problems connected with labour recruitment while public choice theory would look to the growth of private entrepreneurial activity in hospital services and development of market competition in forms of service provision. In this way the growth of private provision for public services can be explained within a theoretical framework, under conditions of economic expansion as well as recession.

To summarise the debate it can be said that public choice and Weberian perspectives ground their analyses in frameworks based on the actions of individuals; either elected representatives or appointed managers. By contrast the Marxian perspective cites pressure for privatisation as being an inevitable outcome of the development of the capitalist economy and the class structure of society engendered by capitalism. In the first two perspectives the explanations rest primarily on the agents (individuals) within society while in the latter it is on the (class) structures of that society.

Neither approach can be rejected but nor can any one of them be applied to the exclusion of the other. A prominent feature to emerge from this research is that the same socio-economic structures at the national (macro) level have produced some very different privatisation policies at the regional (meso) and local (micro) level. Conversely however no privatisation can be said to have taken place in isolation from the socio-economic environment. The development of private provision for hospital ancillary services has in large part been a response to changes in the national economy.

No single theoretical framework therefore can provide a comprehensive explanation of the geographically uneven development of privatisation. Instead it is necessary to invoke all three theories to explain the spatial, temporal, and sectoral dimension of the process. Of equal importance is the recognition that the theoretical frameworks have

different explanatory strengths according to the time, place and industrial sector in which privatisation occurs. Weberian managerialism centring on institutional, locational, professional and managerial factors seems much better equipped to explain the sectoral unevenness of privatisation than either of the other two theories. On the other hand it presents a static analysis with little to say about changes to privatisation over time. Here public choice and Marxian theories fare better with their respective foci on increasing financial constraints and class conflict.

The spatial dimension of the privatisation process at any one point in time often needs to be explained in terms of more than one theoretical framework. So whereas Marxian class conflict theory offers insights into the contemporary spatial pattern of privatisation, the situation that existed in earlier times is more readily explained in terms of a Weberian framework of analysis. In the next section further consideration is given to the inherent difficulties involved in explaining uneven privatisation within a theoretical framework.

10.3 The Limitations of Explanations of the Uneven Growth of Privatisation:

Throughout the empirical part of this thesis it was seen that so many of the explanatory factors operate in a contradictory way with each other. So while smallness of institution was indicative of the desirability of contracting out, it was countered by the remoteness of the location, which applies to many of the small hospital boards in New Zealand. Similarly labour militancy either provoked or revoked contracting out largely depending upon either managerial prerogative or the relative industrial stength of the contending classes. Increasing financial restrictions on an institution have not always induced contracting out if the cost effectiveness of service provision has been deemed incapable of further improvement.

Not surprisingly, therefore, when any of these explanatory variables have been quantified they have not shown any strong correlation with the observed level of privatisation. A further barrier to providing any assessment of their relative importance in presenting an overall explanation is that, as pointed out above, some of these factors have varied according to time, place and sector. So the industrial factor, in the form of workforce opposition to contracting out, has only been an important issue in the 1980s and then only in some of the largest urban centres.

Financial restrictions, on the other hand, started to apply to hospital boards in the 1970s somewhat before labour force opposition arose

to privatisation. Therefore changes to some hospital board's contracting out policies, at the end of the 1970s tended to be founded more on how institutional and locational factors affected the costs of provision rather than on issues of industrial class conflict. Rather than providing a convincing explanation of the spatial pattern of privatisation at any one time, perhaps the major significance of the industrial factor lies in explaining the stagnation in the development of the process after the mid 1980s.

Some of the explanatory factors have played a prominent role at various stages throughout the entire development of contracting out with the managerial one being particularly noteworthy. Contracting out to relieve managerial responsibility has been at least partly mediated spatially by regional variations first in labour shortages and much later in labour militancy. The financial, managerial, and industrial factors all have a temporal and spatial dimension while others, such as the institutional and the locational, have been primarily just spatially variable.

The change over time in these latter two could come about through changes in technology as this might alter the achievement of scale economies, or accessibility criteria, in service provision. Also changes in technology could affect the factor of professional dominance in the sectoral dimension as modernisation may effectively deskill the labour force. This case study of the development of privatisation is perhaps remarkable for the lack of technological innovation to have occurred in the services concerned. A further noteworthy feature has been the virtual insignificance of pluralist politics to the process of privatisation as hospital board members have not generally been elected on a party political basis. It has not then been possible to assign a spatial or temporal dimension to electoral considerations. To the extent that political conditions, and levels of staff professionalism, have affected privatisation it has been more in the sectoral dimension of the process. Services involving the least professional or skilled staff and whose social class category is qualitatively distinct from that of appointed managers and elected regional representatives, have undergone the most privatisation.

When viewed as an aggregate whole it is not therefore possible to cite any one or more factors, at any one point in time, as being of greater explanatory significance than another to the uneven development of privatisation. The prolonged time period over which the growth has taken place - more than four decades - has meant that factors which became

prominent in the more recent periods have operated on an already existing pattern of uneven spatiality. This has rendered the establishment of generalisations in the geographical development of privatisation as being highly problematic.

In this respect parallels can be drawn with recent geographical work in the study of localities and regions as exemplified by Massey (1984) and the CURS' initiative (Cooke 1986). Massey (1984) talks of the effect of new rounds or layers of investment being imposed upon regions with very different social histories and divisions of labour. She argues that, "*the structure of local economies can be seen as a product of the combinations of layers of the successive imposition over the years of new rounds of investment, new forms of activity*" (Massey 1984, 117). As the privatisation process seen in this study has developed over time, and according to the structural conditions of the socio-economic environment, there have been in effect different 'layers' of privatisation. These 'layers' have been imposed over the pre-existing spatial patterns and sectoral distributions of privatisation.

It is perhaps tempting to conclude that each locality/region or, in this case hospital board, is unique and that further geographical enquiry at the scale of concrete reality can but be a succession of case studies in which all attempts at theoretical integration will be forlorn. The shared, even if uneven, economic circumstances of all hospital boards across all time and space have provided the rationale for attempts to cut the ancillary sector work forces. As to whether this has resulted in privatisation has depended upon a series of factors all of which are contingent across time, space and industry (sector) such as regional labour shortages, location of institutions to markets, bouts of labour militancy etc. The search for necessary relations at the micro level has been somewhat less than fruitful as Massey herself found in her 1984 work. It has not been possible to say, for example, that if a hospital has a certain size and location with a certain management and labour force structure, it will or will not privatise its services. Each supportive example can usually be set alongside a counter example.

Thrift (1987, 401) in a rejoinder to Harvey (1987) maintains that there is only a certain amount that can be pulled out of the Marxian tradition to help with the attempts to relate agency to structure and vice versa. He argues that one is forced to look to other traditions for illumination as the research in this thesis has made clear. It has to be emphasised though that appeals to other theoretical frameworks in explaining social phenomena like privatisation must not be to the exclusion

of structural theories grounded in class conflict.

This conclusion however leaves the debate open to what Cochrane (1987, 359) in his critique of Massey (1984) calls a, 'theoretical pluralism' which means using whatever methodology suits the argument at the time and place. So while this allows Massey to, "*move easily - rather too easily - between issues of national and international restructuring and restructuring within individual enterprises*" (Cochrane 1987, 359), in this study different theories had to be applied to explain, for example, the termination of contracting out in Maniototo and Auckland. The separation in time and space and the different contingent factors in each case has prohibited the application of any universal theory. Has then the retreat from structural Marxism, asks Cochrane (1987, 361), "*been replaced by an almost equally unhelpful search for structural relationships at the micro level - by a search for necessary relations where none exist*". Smith (1987) in what he calls the 'Dangers of the Empirical Turn', maintains that Massey had to concede in the end, "*that the case studies of local transformation could not be generalised to provide an overall picture of change in the British space economy but rather had to be viewed as demonstrating only the diversity of potential experiences*" (Smith 1987, 63).

Neither Massey nor any other geographer engaged in locality/regional studies appears to have undertaken detailed studies of privatisation but the conclusion of this research seems to bear a ressemblance to those of Massey. It might be tempting to conclude that locality/regional studies are leading to a theoretical *cul de sac* and amount to little more than a retreat into the empiricism and ideographic studies of yesteryear. While there is certainly a danger of this, the conclusion may be somewhat hasty and is strongly denied by Cooke (1987), responding to the criticisms of Smith (1987), and by Sayer (1989).

In the first place this thesis has only undertaken one major case study and, at the time of writing, a definitive account of the CURS initative in Britain is not available. Secondly, to the extent that a convincing theoretical framework for explaining regional uneven development is still wanting, the empirical approach adopted in this thesis does permit some broad generalisations to be made on privatisation which may be of particular significance in the forthcoming decade.

To take the matter further some comments are made on the current developments in the privatisation of public hospital care in the following sections. This may appear as a shift in emphasis from the previous discussion but it is given on the grounds that it attempts to show how

this research has contemporary relevance for studying the privatisation of public service provision both within, and beyond, the public hospital sector. Guidelines are given for developing further research areas.

10.4 Recent Developments in the Privatisation of Public Hospital Care and the Provision of Ancillary Services:

Towards the end of the eighties major changes started to occur in the provision of hospital services in areas other than the ancillary sector. These changes need to be seen in the context of the increasing financial restraints imposed by central government on all area health (formerly hospital) boards. The immediate result of this has been an extensive reduction and sometimes complete elimination of services in certain institutions. Some of the policies which boards have either implemented, or are giving consideration to are:

a The complete closure of certain hospitals, and the sale or leasing to the private (hospital) sector of others, most of which are geriatric or maternity hospitals.

b The reduction of services at weekends and nights by changing, wherever possible, to day ward only treatment.

c The transference of provision from institutions, especially psychiatric ones, to community care under the guise of a so-called 'normalisation' process.

d The contracting out to the private sector for, i) the care of geriatric patients upon closure of the public hospital and, ii) the provision of all services that are thought to be contestable in the market place. Apart from the ancillary services already discussed this could include pathology, orthotics, transport, gardening, engineering, works and maintenance services.

e The establishment of a Resource Utilisation System (RUS) Consortium[22] to introduce a price mechanism within all boards and thereby set up an internal market exchange process. By imparting a monetary value to all resources and procedures it is intended to place individual departments on a stand alone financial basis and create a greater degree of transparency and accountability across all sectors of the hospital service.

In addition to aiming for cost reductions many area health boards are establishing revenue generating policies. Leasing surplus residential accommodation to the private sector is one example, while another is the contracting in of laundry from private institutions to be processed by the boards' own facilities where surplus capacity is available. A further aspect of the recent privatisation trend in hospital services has come

directly from central government through there being greater deregulation of the market for private hospital growth. Government controls regulating the number of private hospitals that can be established have gradually been removed.

Within the public hopital sector itself it is significant that there has not been, to date at least, any further contracting out of ancillary services. Upto the mid eighties private contracting of ancillary services was resorted to, largely in order to cut costs of service provision and relinquish administrative responsibility. By the late 1980s boards not only had to make far greater cost savings than could be obtained by merely cost cutting in the ancillary sector but in addition were faced with an industrially organised and militant workforce in this sector. Attention then spread to other services to the extent that entire hospitals, or parts thereof, started to be closed. An immediate effect of this was a further reduction, or elimination, of ancillary service requirements.

There are two important differences in the current situation compared with earlier times. The first is that attrition alone is no longer seen by the boards, as being sufficient to reduce workforce numbers to a level consistent with the budgetary allowance and therefore the trade union has had to enter into redundancy negotiations with the boards. Secondly, it is not only ancillary staff affected in these cuts but virtually all hospital staff. Instead of there being a direct attack on the ancillary services though contracting out and competitive tendering, the current cut backs on these services are coming about indirectly through moves to reduce the levels of other services particularly through selective hospital closures. In this case the privatisation process goes a stage beyond private contracting. Where formerly the state was the funder, although not the provider, the withdrawl of services or closure of institutions means that the former function is also relinquished. In such cases both the funding and provision then has to come from the private or even the voluntary or domestic sector.

For ancillary or indeed any other hospital workers the issue becomes no longer just one of resisting productivity increases and maintaining standards of service provision but rather one of trying to counter the liklihood of substantial redundancy. Largely consequent upon the moves to greater community care ('normalisation'), hospital closures and the private contracting of geriatric services, the private hospitals and rest home businesses have increased considerably. As pointed out earlier this growth has also been stimulated by government deregulation of the private hospital sector. Not only are pay and employment conditions considerably

lower in these private places than in public hospitals (see footnote two, chapter nine), but their smaller size and more decentralised location makes workforce militancy much more difficult to organise.

On the basis of these current developments it is worthwhile to recall the comment in chapter three by Ross (1983, 249) that, "*each local advance or reform* [by workers] *may be subverted by the investors ability to evade it by moving again*". While Ross was refering to the geographical mobility of private sector investors it is significant that in the state sector a not too disimilar process has started to occur. Here the state has 'moved', not to a different geographical region but to a different sector. No sooner have hospital workers become industrially organised, albeit in a geographically uneven context, than their advances have started to be subverted by area health boards restructuring and privatising other sectors of the hospital service. As seen this has had adverse flow on affects for the ancillary workers.

Campaigns were amounted by the trade unions to gain seats on the area health boards in the 1989 local body elections with the intention of being able to influence future policy making. In the event none of the Community Health Coalition candidates gained seats on any of the boards in the 1989 elections. With the effectiveness of electoral (political) procedures being seen as wanting, current trade union policy is developing further along what may be called, using the terminology applied in this thesis, a 'managerial' and an 'industrial' strategy.

The first has seen an effort by the Hotel and Hospital Workers Union, in conjunction with the Council of Trade Unions, to have an 'industrial democracy' clause introduced into the 1989 national award document. The basis of this is that:

> The employer and the union recognise that they have a mutual interest in ensuring that health services are provided efficiently and effectively and that each have a contribution to make in this regard (Public Hospital Domestic Workers' Award, 1989, 45).

Although the stated aim of the trade union movement in this area is the defense and ultimate improvement of the public health system (Harris 1989), the policy is born of a recognition that major change is inevitable within the public hospital system.

By following a distinctly 'corporatist' strategy, trade union representatives are seeking an opportunity to become involved in management decision making processes. Through such an initiative it is hoped that the introduction of workforce knowledge and experience into the management structure will illuminate ways for making more effective use of existing

resources without resorting to hospital closures, contracting out and further privatisation. The effectiveness of the policy in achieving this remains to be seen but viewed from a strictly theoretical standpoint it may be observed that trade union policies based on the electoral pluralism of public choice theory have been supplemented, if not supplanted, by those of managerial corporatism.

By contrast with the distinctly Weberian strategy of management involvement in the decision making process, the industrial option relies upon expanding the base of Marxian class conflict. The intention is to enhance both the extent of the public health system and the employment conditions of those working within it. Some sectors of the trade union movement, according to Harris (1989) perceive a desire on the part of government and hospital managements to adopt a particularly hard line towards trade unions from which the latter concludes that there will be no pay off for their co-operation with either of the two bureaucracies. Harris (1989) maintains further that:

> There is a growing call to resist cuts through mass action and it is a direct response to perceptions that the [health board] agenda is to cut back, casualise, contract out and privatise health care, not to restore the integrity of the public health system.

To this end moves have been made both within the trade union movement as a whole and the unions specifically representing hospital workers to replace occupationally based award documents with composite awards based on entire industries. The ultimate aim would be to create a single federation of health service workers covering all grades of employees from cleaners to physiotherapists and drivers to nurses. The establishment in 1986 of the inter-union Combined Health Employees' Committee (CHEC) was a notable move in this direction. Again it is much too soon to see the extent to which such inter-union coordination may be realised. Suffice to say though that a great deal of potential exists for conflict between managerial decisions, made in the name of market efficiency and cost cutting on the one hand and the employment conditions of the workforces and standards of service provision on the other hand. This means that the subsequent development of privatisation in the provision of hospital services in the 1990s should be particularly amenable to analyses within both a Weberian and Marxian theoretical framework. The likely unevenness of implementation should provide much scope for further geographical enquiry.

It is already apparent that the sectoral dimension to the contracting out of hospital services is expanding beyond the confines of the ancillary sector. Within the ancillary sector itself, the question arises as to how

in the 1990s the spatial extent of contracting out is likely to develop. Certainly trade union opposition to the process will remain but with the recent changes to area health boards detailed in chapter five, management will be freer to implement privatisation policies as approval from the elected board membership no longer need be sought. This may not be such a critical factor since earlier work in the thesis showed that the latter, for the most part, has not been much of an impediment in this matter.

On the other hand with the establishment of internal markets, there may be a much lower financial attractiveness for external private provision particularly when the element of contractors' profit is considered. As hospital administration becomes predicated more on the operation of internal markets, the boards may find themselves being required to take management decisions which previously they would have left to contractors. Nevertheless downward pressure on staff numbers may remain for some time to come if cutbacks in other areas continue and to this end temptation will present itself to contract out to avoid having to deal with the militancy of the labour force. Again however the possibility of severe disruption through industrial action, especially if there is an amalgamation of trade union representation on hospital sites, may inhibit the process.

Since many of the policies just outlined are still only at a planning or feasibility stage it has not been possible in this account to detail their precise geographical context. However it should be clear from the work of previous chapters that whatever expansion in private provision occurs, it will do so very unevenly across space. Of equal importance is the realisation that the contracting out of ancillary services represents one of the earliest policy attempts to introduce market criteria into the hospital service and has been something of a forerunner to the current developments in privatisation.

It is therefore important that all the factors found to be relevant in explaining the uneven privatisation of ancillary services are also considered when studying the process in other sectors of the public hospital system. Financial constraints on the area health boards may be instrumental in stimulating further privatisation. The empirical research conducted here though makes it clear that the response to such constraints in respect of privatisation will probably be very uneven geographically. This thesis has demonstrated that different institutions operating within the same economic environment adopt very different policies regarding their form of service provision. In this way the work of Ascher (1987) on contracting out and the contributions to Scarpaci (1989a) have failed to

provide a comprehensive analysis of why the process of privatisation develops unevenly across space within any given set of economic and political conditions.

In spite of the limitations of explanations appealing to any one theoretical framework, it is claimed here that only by examining the interacting and counteracting empirical factors identified in this thesis can an understanding be gained of the geographical development of privatisation. It must also be stressed that the methodological approach adopted in this thesis should also have applications to many other sectors of the public economy beyond that of hospital care. In the following section some comments are made on the likely trajectories for public service provision in the coming years by drawing some theoretical conclusions from the empirical work undertaken here.

10.5 Geographically Uneven Privatisation Beyond the Public Hospital Sector:

The empirical case study in this thesis has shown that public hospital ancillary services in the late 1980s have come under increasing pressures but without further privatisation by contracting out. It is primarily service cut backs in other sectors of the public hospital service that are having, albeit indirectly but no less dramatically, such an adverse affect on the ancillary sector workforce. Possibly the major lesson to be drawn from these current developments, and from the thesis as a whole, is that the contracting out process for service provision can eventually result in the curtailment of the entire service. By the time hospital ancillary workers became sufficiently organised industrially, in certain regions at least, to resist some of the changes brought about by private contractors, the effectiveness of this militancy has been undermined as reductions and reorganisation take place in other sectors of the hospital service.

Private contracting of a public service may be resorted to as a first attempt at cutting the costs of state provision with the geographically uneven development of the process depending on at least some of the factors indentified in the case of hospital ancillary services. For example in a deregulated transport industry, passenger transit services could be put out to competitive tender with the result being a very uneven geographical distribution in the private/public mix of service provision. In some regions the services might be retained under public (state) provision, while in others they would be contracted out to the private sector. Cases might also exist in which there is sufficient resistance on the part of public body managements and/or work forces that in some regions the

tendering out initiative itself is inhibited. Whatever situation prevails the spatial development of privatised service provision is likely to be highly uneven across space.

Precisely the same analysis could be applied to many other public services that are administered on a regional or sub-national basis. In the specifically New Zealand context the recent reorganisation of local government administration and the imminent deregulation of urban passenger transport will doubtless result in a distinctly uneven geographical pattern to the privatisation of many public services throughout the next decade. To the extent that these initiatives are occurring as a perceived need to reduce levels of state expenditure, serious consideration should be given by user groups and employee organisations to the possibility of service reduction if not eventual elimination.

Increasing restraints on public expenditure may therefore see pressure to eliminate some contracted out services entirely, with the ultimate effect being that the public sector economy contains a greater predominance of revenue generating or commercial services. There remain however a variety of public services that could not conceivably be revenue generating but whose provision must always be ensured by the state. Municipal refuse collection, highway maintenance and the hospital ancillary services considered in this study would be typical examples. These services may be subjected to privatisation through contracting out to the private sector but their continuity must be ensured to maintain basic public health or economic (productive) activity.

When considering services that are provided in an institutional context, like public hospitals and schools, their component services such as cleaning and maintenance may be contracted out as a first cut at cost reduction. Similarily state subsidised passenger transport services or post offices may be contracted out to private (or voluntary) operators in the first instance. The provision of these contract provided services is ensured for as long as the funding authority - the state - is prepared to continue in its capacity as funder. Once this funding is no longer forthcoming then the entire school or hospital may close and the transport or postal retail service is discontinued. In these situations any residual provision tends to fall to the voluntary or domestic sector as there would not generally be sufficient commerical viability in the services to attract the private sector.

Those state services regarded as revenue generating or commercial can be established as business (ie profitable) enterprises with the further option of sale to the private sector if desired. On the other hand those

that do not fall into this category insofar as they cannot generate any revenue or at least sufficient to be judged self financing present themselves as immediate candidates for contracting out to minimise costs. If still greater cost reduction are deemed necessary, then the service or institution can only be suspended or closed. Lack of potential profitability in these cases inhibits the entry of the private sector and so the voluntary sector is required to undertake provision. The extent to which many state funded, but privately provided, services remain provided at all could be a matter of intense political and industrial conflict during the decade of the 1990s.

Returning to the geographical context of the debate, these conflicts may be highly fragmented spatially in view of the uneven development of public service privatisation and curtailment. This observation should spark a note of caution in the undertaking of locality studies in respect of privatisation. According to Cochrane (1987, 361) there is a danger that locality studies may, "*reflect a shift away from attempts to confront or challenge capital at the national (let alone international) level and implies that instead we can approach the problem on a piecemeal basis: sector by sector, type by type, locality by locality, unique labour process by unique labour process*" to say nothing of hospital board by hospital board. By way of example the spatially fragmented nature of the workforce opposition to private contracting of hospital ancillary services may be recalled for its inability 'to clean out contractors' across all space. Moreover the fragmentation of workforce opposition across sectors of the hospital service has also had a divisive affect on a variety of grades of hospital worker both within, and outside of, the ancillary sector. Findings of this nature beg the question of how future geographical enquiry into public service provision could proceed and this issue is addressed in the concluding section.

10.6 Future Directions in Geography: Some Concluding Comments:

'What is left to do?' is the challenging question posed by Walker (1989). In the paper he presents a spirited defence of the relevance of Marxian methodology to the discipline of human geography. Being so broadly focused it is rather long on generalisation and extremely short on specifics. While it is hard to disagree with Walker (1989, 160) that, "... *we must continue to learn and expand our understanding of the world and how it must be changed...*", he gives little indication of the precise nature of research required to realise this ultimate goal. His claim that "... *historical geographical materialism remains an irreplaceable tool for social scientific insight and political direction...*" is well made. Yet

the question still remains as to what specific form of research should be engaged in by geographers who are committed to working for enhanced and improved public service provision.

The question of why privatisation takes place in region or industry A but not B has been addressed in this thesis using both Marxist and non-Marxist theories. The main justification for this multitheoretical approach is that an analysis based only on a single theoretical framework will lead to an incomplete understanding of the privatisation process. This in turn could result in an inappropriately formed campaign of opposition by those adversely affected. Gaining a comprehensive knowledge of why such processes as privatisation develop unevenly within a similar socio-economic environment must be the first, if not the most fundamental, point of entry for future geographical enquiry. Clearly Marxian class conflict theory cannot, nor will not, be able to explain adequately the future regionally uneven development of public service provision and neither for that matter can the individualist framework of public choice and Weberian perspectives.

The particular appeal of Marxian informed enquiry as illustrated by this thesis, is the way in which concerted campaigns of labour militancy can substantially alter the geography of privatisation. In so doing, business is then forced to look elsewhere for its profits, either in other geographical regions, or in sectors of industry, where the workforce is less well organised. If nothing else this thesis has demonstrated that labour force militancy has been a potent force in inhibiting the drive to privatisation in hospital services. The extent to which this conclusion is valid in industries outside of the health services is particularly worthy of future research.

For developing a geography aimed towards identifying political strategies for enhanced public service provision much closer attention should be given to studying how people resist and challenge policies that seek to privatise and dismantle public services. This will first require an understanding of why the policies of privatisation and service reduction are implemented in a spatially uneven manner since the formation of appropriate oppositional strategies may have to take different forms in different regions. So while in one geographical context electoral campaigning and public protests may be the most effective policy, in another large scale industrial action would be called for. Also to be considered is the potential for the mutual reinforcement of oppositional campaigns. For example, public protests aimed to prevent hospitals and railway services from closure and cut backs should be analysed for their

ability to reinforce the industrial action that may be taken by the workforces in those services affected by job loss and reduced working conditions.

In no way is it suggested that various modes of resistance adopted have been or always will be successful in their endeavours but this in itself calls for further research if only to try and understand why a campaign in one region succeeds whereas in another it may fail completely. A common tendency in both Marxist and non-Marxist social and industrial geography is to portray people, whether in or outside of the labour force, as being almost passive bystanders in the whole capitalist restructuring process. While the earlier quote from Ross (1983) points to the relevance of class opposition to capitalist restructuring his account neglects to detail the specific mechanisms by which labour has made advances in one region while undergoing setbacks in another.

Redfern (1987) admonishes Marxist geographers with the well known quote that the point is, 'not to understand the world but to change it'. and he argues that, "*all the historical materialist studies in the world are so much fatuous posturing if they are not capable of advancing that end*" (Redfern 1987, 417). This is certainly a persuasive viewpoint and the research in this thesis has provided a concrete example of how, if not the world, then certainly the geography of privatisation can be changed. It should also be stressed that Redfern's challenge is also applicable to all geographers who retain a concern for expanding and strengthening the public sector economy, be they Marxist or otherwise. Walker (1989, 153) maintains that, "*the relation between practical activism and worthwhile scholarly analysis is surprisingly loose*" while Redfern taunts Harvey to, "*abandon the Capital reading groups for a while and go canvassing for the Labour Party in Oxford during the next election*" (Redfern 1987, 417). Although verging on the polemical the point remains that much greater attention to details of people's working life 'at the coal face' would enable human geography to attain a more profound and progressive social relevance in the coming decade.

With the likely expansion of privatisation and deregulation, not only in Western but perhaps increasingly within the Eastern bloc countries as their economies undergo major transformation, it is perhaps appropriate to finish on Harvey's rejoinder to those who demur from applying the 'totalising' perspective of Marxian methodology. What according to Harvey (1987, 374) is more 'totalising' than, "*the penetration of capitalist social relations and of the commodity calculus into every niche and cranny of contemporary life*". The highly uneven way in which privatisation

ensures, 'the re-establishment of capitalism', to return again to Lord King's phrase (chapter one), clearly demonstrates that 'geography matters'. But as the totalising force underlying the privatisation drive, the question may be posed *pace* Massey, does geography <u>really</u> matter? For understanding the development of privatisation, and its effects upon public services, it is imperative that the capitalist economy is considered as a totalising force and not a geographically fragmented one operating in a merely localised or regional context.

<u>Footnotes:</u>

1 CURS: Changing Urban and Regional Systems.

2 The RUS Consortium comprises the Department of Health, Hospital Boards' Association and the RUS management board.

APPENDIX 1

Analysis of Variance (ANOVA) in Relation to Hospital Board Size (by Bed Numbers) and Number of Ancillary Services Contracted Out

The 29 hospital boards (n=29) are grouped into 4 categories (k=4) according to the number of services contracted out. The number of services can range from 0 to 3. The size of each hospital board is given by its number of beds X for the years 1976, 1981, 1986 and 1989.

The degrees of freedom between the groups is given by $k-1 = 4-1 = 3$
and within the groups is given by $n-k = 29-4 = 25$

Research hypothesis: Variation between the groups is greater than the variation within the groups.

Null hypothesis: Variation between the groups is less than the variation within the groups.

Analysis of Variance for Hospital Board Size

Source	Sum of Squares	Degrees of Freedom	Variance or Mean Square	F ratio
		1976		
Between Groups BSS	12,864,759	3	s_B^2 = BSS/(k-1) = 4,288,253	F = s_B^2/s_ω^2 = 3.70
Within Groups WSS	28,964,791	25	s_ω^2 = WSS/(n-k) = 1,158,592	
Total	41,829,550	28		
		1981		
Between Groups BSS	16,160,582	3	s_B^2 = BSS/(k-1) = 5,386,861	F = s_B^2/s_ω^2 = 6.41
Within Groups WSS	21,024,738	25	s_ω^2 = WSS/(n-k) = 840,990	
Total	37,185,320	28		
		1986		
Between Groups BSS	15,585,955	3	s_B^2 = BSS/(k-1) = 5,195,318	F = s_B^2/s_ω^2 = 7.76
Within Groups WSS	16,744,650	25	s_ω^2 = WSS/(n-k) = 669,786	
Total	32,330,605	28		
		1989		
Between Groups BSS	6,912,129	3	s_B^2 = BSS/(k-1) = 2,304,043	F = s_B^2/s_ω^2 = 2.67
Within Groups WSS	21,533,147	25	s_ω^2 = WSS/(n-k) = 861,326	
Total	28,445,276	28		

At 0.01 (1%) significance F = 4.68
At 0.05 (5%) significance F = 2.99

APPENDIX 2

Calculation of Index of Privatisation for Ancillary Services in New Zealand Hospital Boards

For each of the years under consideration, hospital boards have been indexed on a scale from 0, where there is no contracting out anywhere, to 100 in which case all ancillary services are contracted out at all board institutions. A 'privatisation index' P (say) is developed in which the total number of services contracted out S (say) in any board is weighted by taking the ratio of bed numbers in the institutions I (say) which use contract services to the total bed numbers T (say) in the entire hospital board. With three services being the maximum number to be contracted out, (the fourth, laundry, is not contracted out and hence not considered) the final expression is multiplied by 100/3 to reduce the index to a value between 0 and 100.

The level or index of privatisation for any given year can then be calculated from the formula $P = 100[S \times I]/3T$. Data on bed numbers comes from the annual publication *Hospital Management Data*, which was only operative from 1975 to 1988 while 1989 data, which is the most recent available, was supplied by the Department of Health Statistics. It has not been possible to develop the index prior to 1975.

In summary form Y = Index of Privatisation and is given as:

$$\frac{100 \times [\text{Services Contracted}] \times [\text{Beds in Hospitals with Contractors}]}{3 \times [\text{Total No. of Beds in the Hospital Board}]}$$

where X = Total bed numbers in each of the 29 boards.

APPENDIX 3

Adjustments to Hospital Board District Populations for Cross Boundary Flows of Travellers (after Barnett *et al* 1980)

By the term 'travellers' is meant persons who, on census day, are being treated in boards other than the one in which they normally live (Barnett et al 1980, 255). The original base board district population figures are amended to account for travellers according to the formula:

$$N_{Ai} = N_{oi} \mp N_{Ti}$$

where

$$N_{Ti} = (ti/pi) \times (Pi/r)$$

and

N_{Ai} = Adjusted population of hospital board i

N_{oi} = Original base population of hospital board i

N_{Ti} = Population from (to) which net travellers drawn (dispersed) for hospital board i.

ti = Net travellers, hospital board i, on census day.

pi = Inpatient numbers, hospital board i, on census day.

Pi = Inpatient numbers, hospital board i, for whole year.

r = Inpatient admission rate for whole of New Zealand.

The direction of the sign in the equation is determined by whether there was a net inflow (or outflow) of travellers to (or from) each hospital board. A basic assumption of the formula is that census night is typical for all nights throughout the year. The data on net travellers and inpatient numbers is drawn from *Bed Occupation Survey* 1981 and *Hospital Management Data* 1981, both issued by the National Health Statistics Centre, Department of Health, Wellington.

APPENDIX 4

Methodological Considerations in the Gathering of Data and Information on the Contracting Out of Public Hospital Ancillary Services.

The methodological approach adopted in this thesis has been aimed at testing empirically the validity of three major theoretical frameworks that purport to explain the development of privatisation policies; public choice, Weberian managerialism, and Marxian class conflict. The application of these theories to the case study required the collation of a very broad range of data and information. This requirement had a major affect on the methodology adopted in the empirical research since the information and data required did not exist uniformly across either space or time. Consequently it was not possible to approach the research using rigorous data sampling methods and survey techniques. Instead the research methodology had to be sufficiently flexible and informal to cope with the spatially and temporally variable extent to which the information and data was available. The effect of this was that the methodological approach tended to develop as the research proceeded.

In order to test the applicability of the three theoretical frameworks, the critical issue was to explain why New Zealand hospital boards resorted to private contracting for their ancillary services. Of particular interest was the issue of explaining the variations that existed between different hospital boards in their rationale for contracting out ancillary services.

Prior to seeking these explanations for geographically uneven privatisation it was, however, first necessary to determine precisely the extent to which the policy had been adopted across both space and time. This necessitated gaining a knowledge of the growth of private contracting within, as well as between, the different hospital boards. In the first instance this was achieved by entering into written correspondence with the Chief Executive or General Manager of each of the 29 hospital boards. The main question they were asked, was whether their respective board had ever used private contractors for ancillary service provision.

If they had four further questions were asked. First was which hospital(s) within the board used contractors, second was the name of the contracting companies concerned, third was which particular ancillary services (ie domestic cleaning, orderlies, dietary, laundry) had been contracted out and, finally in which year did contracting out commence or cease. All 29 boards responded to the approach with 25 reporting the use of private contractors and all of these responding to the next four

questions. With this information it was possible to establish, in cartographic form, the spatial development of private contracting over time. It has also been possible through this initial written correspondence to determine which private contracting firms were responsible for providing the ancillary services.

Having established the basis of the geographical development of private contracting, the next task was to seek explanations for the spatial patterns ascertained from this initial survey and to find out the reasons for private contracting. This necessitated personal visits to each of the 25 hospital boards that had used contractors, whether currently or at any time in the past. While initial contact had been with Chief Executives or General Managers, in accordance with accepted business practice, further contact was directed specifically to the manager directly concerned with currently contracted out services.

In most cases the research enquiries were directed to the Supplies Officer of the hospital boards' central administration as this person had overall responsiblity for contract ancillary services. Some very small boards did not have a specialised Supplies Officer and so enquiries were then address to either the Chief or Deputy Chief Executive or the Accountant depending upon who had most experience with the contractors. In the large hospital boards of Auckland, Waikato and Wellington there was some delegation of responsiblity for contracting out to the local hospital level, the Hospital Manager or Chief Administration Officer of the institution concerned was also interviewed. Through this procedure it was possible to interview all hospital board managers who currently had responsibility for contract ancillary services. A total of thirty five hospital managers were interviewed during the course of the research.

One of the major difficulties in gathering information on contracting out for earlier years, was that almost invariably the hospital manager concerned was no longer employed by the board, and upon enquiry could not be traced. Of the 20 hospital boards that first started contracting out prior to 1965 it has only been possible to trace one manager, formerly of the Vincent Board, who had active involvement in contracting out in these early times. Even for contracting out in more recent times this was sometimes a problem where there had just been a change of management staff. In cases where managers had left a board's employment all attempts to trace their whereabouts were unsuccessful. In compensation there were managers in mny boards who had a long history of employment in the same position and who were therefore exceedingly knowledgeable on the subject of contract service provision over time. Often this significantly

to compensated for the absence of certain previously employed management staff.

Interviews with hospital managers could be supplemented in 16 boards by examination of written records on contracting out. These records assumed several different forms. A prominent part consisted of letters that had been exchanged between hospital board managers, private contractors, trade union officials, and managers in other hospitals. Internal memoranda relating to contracting out that were exchanged between the managers of a hospital board also featured prominently amongst the records. The tender documents and conditions of contract supplied by boards to the contractors had also often been preserved, along with the tenders that the prospective contractors submitted to the boards.

Another important source of recorded information was the reports submitted by hospital managers to the elected board membership. These reports were significant for the revealing way in which they recommended either the commencement, continuation, alteration or termination of a particular contract. Where the subject of contracting out had aroused media attention, as for example in the case of industrial disruption, extracts from local newspapers were also found in the records of many boards. These extracts provided a useful basis for establishing the existence of an industrial relations problem in a board and stimulaed further investigation in this area. The Otago Board was distinctive insofar as it possessed a very detailed collection of newspaper cuttings from various parts of the country and this proved to be very useful in ascertaining the number of industrial disputes concerning ancillary staff both in the Otago Board and others throughout the country. Advertising and promotional material from contracting companies featured prominently amongst the preserved material and provided a major source of information on the business activities of these companies. Finally, circular letters from the Department of Health on the subject of contracting out had also been kept on file in most boards.

An important point to emphasise with the hospital board records is the variation in consistency between the boards. This variation occurred both in the time span covered by the records and the amount of information they contained. In some boards no records at all were available although it was not always possible to determine whether this was due to their absence or to being withheld from view ostensibly to preserve confidentiality. For example Wanganui, Palmerston North, Dannevirke, Thames and Tauranga had no records available for inspection. For the most part however hospital boards were readily prepared to open their records

and certain boards were noteworthy for the comprehensive nature of the information detailed. The Wairarapa Board was particularly useful for its records which extended back to the late 1940s. Canterbury Hospital Board records were also instructive in this respect while for information on the more contemporary developments in contracting out, Auckland, Northland, and Otago were especially useful.

Unfortunately there was often little consistency between boards in what was preserved and sometimes the records were fragmentary with important time periods missing. This variability in documentation prevented more detailed research being undertaken particularly regarding the termination and commencent of many hospial contracts in the late 1970s and early 1980s. Nevertheless the records that were available proved to be an invaluable source of information both for ascertaining the different reasons for contracting out and for relating these reasons to the theoretical frameworks of the thesis. An attempt is made in table *1* to summarise the extent to which records and knowlegeable personnel were currently available in the hospital boards.

In addition to the hospital boards, correspondence was also entered into with all eight regional branches of the Hotel and Hospital Workers' Union to obtain information on the ancillary workers' response to private contracting. Five of these branches were also visited; the Northern (Auckland), Wellington, Canterbury, Otago and Southland. All except Southland were visited on two or three separate occasions. The people interviewed were either the branch secretaries or the organising officials depending upon who was most knowledgable on contracting out. As the opportunity was also taken to interview these officials at national trade union conferences this eliminated the necessity of additional personal visits to some branch offices. Unfortunately written records kept by the trade union branches on contracting out were far more sparse than in the case of hospital boards. Most of the information had to be gained from oral interviews with both trade union officers and work site union delegates.

The lack of written records required the reliance on the circulation of questionnaires, an example of which is shown in figure *1*. This was used to gain details on the geographical variations in labour force militancy and was distributed to all branches of the Hotel and Hospital Workers' Union. The usual limitations in this approach to data collection apply; some questionnaires were never returned, some were incomplete and sometimes the data supplied was inconsistent with information available from other sources. Perhaps the greatest source of inaccuracy came from the

TABLE *i*: The Availability of Information in New Zealand Hospital Boards on the Contracting Out of Ancillary Services

Hospital Boards	Availability of Documented Information	Extent of Knowledge Possessed by Management on Contracting Out
Auckland	Excellent	Good
Canterbury	Excellent	Good
Otago	Excellent	Fair
Waikato	Fair	Fair
Wellington	Poor	Fair
Hawke's Bay	Poor	Poor
Northland	Excellent	Excellent
Palmerston North	Poor	Poor
South Canterbury	Fair	Fair
Southland	Poor	Good
Taranaki	Good	Good
Tauranga	Poor	Fair
Wanganui	Poor	Good
West Coast	Good	Good
Ashburton	Fair	Fair
Bay of Plenty	Poor	Poor
Dannevirke	Poor	Fair
Maniototo	Poor	Fair
Marlbourgh	Poor	Fair
South Otago	Fair	Good
Taumarunui	Fair	Fair
Thames	Poor	Fair
Vincent	Fair	Fair
Wairarapa	Excellent	Excellent
Waitaki	Poor	Good

Waiapu, Cook, Central Hawke's Bay and Nelson are excluded from this table as there has been no history of contracting out ancillary services in these Boards

FIGURE 1: Survey of Industrial Action taken in New Zealand Public Hospitals by Members of the Hotel and Hospital Workers' Union

1 Year of Industrial Action	2 Institution or Hospital where Industrial Action Occurred	3 Category of Workers taking Industrial Action	4 Number of Workers taking Industrial Action	5 Form of Industrial Action	6 Duration of Industrial Action	7 Reason for taking Industrial Action

Explanation of Table

1 Year of Action:

The year and, if possible, the month(s) when the industrial action occurred

2 Institution or Hospital:

Name of Institution(s) or Hospital(s) where industrial action occurred

3 Category of Workers Involved:

Were the workers taking action, domestic orderly, or kitchen staff?,

4 Number of Workers taking Action:

An approximate number will suffice if exact number not known

5 Form of Industrial Action:

Was the action taken 'limited' (eg not performing certain regular duties) or was it a complete work stoppage

6 Duration of Industrial Action:

Approximate number of hours, days or weeks over which action took place.

7 Reason for taking Industrial Action:

For example
- breakdown of National Award Negotiations
- dismissal of worker
- excessive staff reductions and/or work loads

Your assistance in supplying this infomation is much appreciated. Please return to: John Stubbs, c/o Department of Geography, University of Canterbury, Christchurch 1.

unavoidable necessity of relying on people's memories to recount certain events. Sometimes details of an event in one region had to be acquired from another region particularly where there had been a rapid turnover ofpersonnel.

Apart from the hospital boards and trade union branches, the two other sources of information were the private contractors and the central government's Department of Health. For the former, the main limitation was that so many firms that once supplied hospital ancillary services had gone bankrupt, and little or no information was available on them. Indeed it was only from hospital board records that any details of these firms could be found. Even the largest contractor currently providing hospital services (United Health Services) claimed to have no written records of their dealings with hospital boards and trade unions. Aside from what was found in hospital board records, the gathering of information on company activity could only be ascertained from oral interviews with management personnel at both national and regional levels.

Information from the head office of the Department of Health was sought on two accounts. The first was to obtain data on the annual financial allocations to the individual hospital boards, while the second was to gain details of the role the Department played in hospital boards' contracting out policies.

For collating statistical information the only published source of data was the annually produced *Hospital Management Data* by the National Health Statistics Centre of the Department of Health. A serious limitation of this publication was that it was only produced between the years 1975 and 1988 and so it only covered part of time span considered in the thesis. In addition to this there were also problems associated with the data itself particularly as it related to the ancillary services. These difficulties have been detailed at appropriate places throughout the text, (see for example chapter five, page 114 and chapter eight page 206) but in brief they amount to the existence of a lack of conceptual clarity underpinning the terms for which data has been collated. For example the concept of housekeeping services was not clearly defined. Consequently, there tended to be a lack of consistency in the compiling of data both across space (ie between the hospital boards) and time. With there being no other source of published data available, this problem was unavoidable but possible discrepancies were minimised by making individual enquiries to various hospital boards seeking confirmation or reassesment of the data they submitted to the National Health Statistics Centre.

In terms of field work for the research, most of the time taken was

devoted to visiting hospital boards. Contact with trade union offices, contractors, and the Department of Health was usually coordinated along with visits to the hospital boards. The initial field work for the thesis was done at the offices of the local Canterbury Hospital Board during the months of September and October of 1988. The entire month of November 1988 was spent visiting all North Island hospital boards where services had been contracted out. Only Waiapu, Cook and Central Hawkes Bay were excluded as there had not been any contracting out in these Boards. For the same reason no visit was made to the Nelson Board in the South Island.

The initial field work was completed during the first half of 1989 by visiting the remaining South Island boards. After completing this first survey of the hospital boards to gather all the available data and information, the remainder of the field work consisted of additional visits to the Northland, Auckland, Waikato, Wellington, Wairarapa, Canterbury, Ashburton and Otago Boards. While the first visits had been undertaken largely to ascertain why services were contracted out, the purpose of the subsequent visits was to determine how the privatisation process occurred. This required gaining a knowledge of the lines of communication that existed between managers within the boards and the how policy decision were made. Another reason for follow up field work during 1989 was to clarify issues arising from the incomplete nature of the written infomation and the often inconsistent statistical data available. Detailed field work on the management structure and the ancillary work force of the Auckland and Northland Hospital Boards, was conducted during January and February 1990. Often trade union offices were also visited during the course of this subsequent field work.

In summary, and to emphasise the point made at the beginging of this section, the existence of data and information on contracting out has been exceedingly variable in both quality and quantity. The forgoing account has attempted to detail the extent to which data was available for this research. While in many respects the data has been suboptimal, there has often been a sufficient supply of written documentation from various sources to provide an understanding of the geographical development of contracting out.

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